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Delivery and Engagement in Public Health Nutrition:

The use of ethnographic fiction to examine the socio-cultural experiences of food and health among mothers of young children in Skelmersdale, Lancashire.

Thesis submitted in accordance with the requirements of the
University of Liverpool for the degree of Doctor in Philosophy

by

Rebecca A. Gregg

April 2013

Abstract

Background: Encouraging good nutrition is particularly important in the early years of life for the development of appropriate food habits and healthy adults in later life. These are governed by many contending and conflicting influences.

Objective: This research examines the food choice influences for mothers of young children in Skelmersdale, West Lancashire (UK).

Participants: Participants were recruited from a large community food intervention (clients) and were compared with those not involved in the initiative (non-clients). This enabled the reflection of the broader socio-cultural experiences of food and the influence of “structure” and “agency” on food choices.

Methodology: The research adopted a phenomenological approach using ethnographic recording techniques (interview and observation). The research findings are presented as ethnographic fictions. These short fictional stories provide a “thick” description of the participant’s lifeworld. They locate these choices in the person and the place.

Findings: A hierarchy of food choice influences emerged from the data, with three main findings. Most prominently, the influence of individual capacity on the food choices made. Secondly, the influence of place, town planning and the geography of an area on food choices. Thirdly, the influence of gender, relationships and social networks.

Conclusion: Central to the thesis of this research is the use of ethnographic fiction to enable a better understanding of the complexity involved in food choice and community development approaches to nutritional change. The

use of ethnographic fiction conveyed a better understanding of people and of the role and impact of an intervention upon the wider processes involved in food choice. Ethnographic fiction was used here for the first time in public health nutrition to explain the complex picture of food choice for mothers of young children in Skelmersdale, and to convey new insight on food choice and the complexity of food choice influence.

Key words: Empowerment, Ethnographic Fiction, Food Choice, Food Choice Capacity, Geography, Health Inequalities, Intervention, Evaluation, Public Health, Socio-economic Factors, Storytelling, Thematic Analysis, Women

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Abbreviations

BMI	Body Mass Index
CBI	Community Based Initiative
CD	Community Development
CFI	Community Food Initiative
CAN	Community Nutrition Assistants
DH	Department of Health
EF	Ethnographic Fiction
GIS	Geographic information systems
HI	Health Inequalities
JSA	Job Seekers Allowance
LIDNS	Low Income Diet and Nutrition Survey
LFHW	Lay food and health worker
LSOA	Lower Super Output Areas
NDNS	National Diet and Nutrition Survey
NHS	National Health Service
PHN	Public Health Nutrition
SCFI	Skelmersdale Community Food Initiative
UK	United Kingdom
WHO	World Health Organisation

Chapter One:

Introduction and Background

1.0 Introduction

1.0.1 Contribution of research project to knowledge in Public Health Nutrition

Food choices are governed by far more than physiological requirements.

Buttriss et al. (2004) define food choice as:

The selection of foods for consumption, which results from the competing, reinforcing and interacting influences of a variety of factors. These range from the sensory, physiological and psychological responses of individual consumers to the interactions between social, environmental and economic influences, and include the variety of foods available and the activities of the food industry to promote them (Buttriss et al., 2004b, p. 7)

These choices are embedded in a jigsaw of contending and conflicting influences that ultimately have an impact on health. However, there is no clear picture of the main influences on food choice that contribute to diet-related health inequalities. Public health policy acknowledges wider socio-economic factors, but is limited by the availability of effective approaches ("on the ground") to address them. Community food initiatives, which have been at the centre of public health policy as a means to tackle such inequalities, are yet to

demonstrate their ability through the research literature to address this imbalance (Dowler & Caraher, 2003).

Health and disease cannot be defined merely in terms of anatomical, physiological or mental attributes. Their real measure is the ability of the individual to function in a manner acceptable to himself and to the group of which he is a part.

(Dubos, 1984 as cited in Dowler & Calvert, 1995 p. 759)

As this quote from Dubos exemplifies, the choices we make regarding health are not always as conscious, rational beings or a case of “behaving badly”. They are a construction of many complex influences which come together to confirm the normative values of the groups with which we are part. This research explores the contexts and discourses attending food choice for mothers of young children, to enable a deeper understanding of the many influences and the connectedness of these influences.

This research employs qualitative social research methods to analyse the forces affecting the food choices made by mothers for themselves, their young children and their family. In particular, it uses ethnographic fiction as an innovative means through which to convey these findings in an effective manner. This research also determines how these choices are influenced by participation in a community intervention. This enables a better understanding of the effectiveness of intervention strategies to address diet related health inequalities.

Central to the original contribution of this research is the use of ethnographic fiction to enable a better understanding of the complexity involved in food choice and community development approaches to nutritional change. This study enables better comprehension of food choice mechanisms, of community development approaches to nutritional change and, produces new insights into how to measure the worth of community approaches to addressing diet-related disease.

Two meta-questions are raised for examination in this thesis; firstly, are the most appropriate approaches fundamental to the improvement of health inequalities being used? Secondly, are the most appropriate outcome measures and approaches to evaluate and present these outcomes being used, so that they are of use to health policy and professional practice?

1.0.2 Study aims and objectives

This research is informed by the theoretical perspective of community development (CD). CD is a process that aims to address social imbalances, inequalities and stresses working together with communities to bring about change (NOS CD, 2009). The research therefore aimed to generate a better understanding of the influences on food choice for mothers of young children and, the role of a community food initiative for bringing about nutritional change. In doing so, the research addresses any limitations in policy and practice at present and informs the wider debate on diet-related health inequalities in the UK.

To meet the above aim, there were a number of objectives for the original study. This initial investigation and process enabled the insight for the PhD thesis to emerge, that is, the use of ethnographic fiction to understand and articulate the complex picture of food choice for mothers of young children.

These objectives were to:

1. Compare the determinants of food choice for food initiative clients and other persons (non-clients) to broaden the scope of food projects to acknowledge any unintended outcomes;
2. Develop a deeper understanding of the wider socio-economic influences on food choice for mothers of young children in the UK;
3. To enable the development of new methodologies for determining food choices influence. This will enable a greater understanding of the role and impact of an intervention and the wider processes of food choice;
4. To perform an analysis in relation to individual capacity and other determinants of food choice by interrogating the findings through community development (CD) theory;
5. To provide a geographic interpretation of health inequality as a component of food choice;

6. To make an interpretation of the data based on gender influences, including an exploration of social networks and parenthood influences on food choice.

The thesis is structured as follows. This opening chapter explores the association between modifiable dietary and lifestyle behaviours and non-communicable disease, and presents what is known from the academic literature in relation to diet, the health gradient and its link to certain socio-economic variables.

Chapter 2 provides a contextual grounding for the substance of the thesis. It outlines a number of the significant influences that affect our food choices in the UK. It addresses the policy context in relation to the research, firstly from a historical standpoint and then by outlining the contemporary policy perspective. It goes further to examine the research base for food and health initiatives and the issues inherent in the evaluation of these projects. The chapter goes on to provide a theoretical underpinning for the research, a discussion of community and change theory.

Chapter 3 addresses the theoretical and methodological limitations of current research on nutritional change. It then gives details of the research, the research setting and the community food intervention that is part of the research. It outlines the epistemological perspectives behind the research, the implementation process and the data sorting and analysis procedures. Finally,

it explains ethnographic fiction and its use over conventional qualitative methods in understanding food choices and community interventions. It concludes with a critical discussion of the methods employed.

Chapter 4 provides an overview of themes, displaying the influences on food choice for mothers of young children as derived from NVivo analysis. The influences are displayed as a hierarchy, which identifies the most important influences for participants.

Chapters 5, 6 and 7 are discussion chapters, each addressing the most influential and unique findings of the research regarding both clients and non-clients. Within each chapter, ethnographic fictions (EF) present the research findings; these are short fictional stories that draw on actual data gathered in the field, which have the ability to convey a complex picture of food choice. Although a relatively new and innovative method for communicating research findings, EF arguably has the capacity to allow the reader to engage more deeply in the lifeworld of the participants than other methods. The ethnographic fictions are then discussed in relation to the empirical and theoretical research. Individual capacity is the focus of chapter 5, which is analysed in relation to community development theory, agency and the role of the community food worker. Gender roles and relationships are discussed in chapter 6 with regard to the importance of parent-child relationships, socialisation and social networks. The last outcomes chapter, chapter 7, demonstrates the importance of the built environment; it examines both the

physical and social function of the surrounding environment showing the impact of place as opposed to space, on the food choices of mothers.

Chapter 8 concludes by drawing together the varied outcomes of this research; how the wider social environment affects food choice in Skemersdale and the influence of individual capacity that is the ability problem solve and overcoming barriers to health. Finally, this chapter analyses the use of ethnographic fiction to enable a better understanding of food choices and community development approaches in nutrition interventions. The chapter makes recommendations for practice in public health nutrition and further areas for research in the field.

1.1 The relationship between diet and health

Human health is inseparable from diet. Significant levels of illness and mortality have been attributed to poor dietary behaviours such as the consumption of excessive amounts of energy, a low intake of fruit and vegetables and fibre (WHO & FAO, 2003). When compared with a range of European countries the UK has been classified as having the most advanced quantitative targets for tackling health inequality such as life expectancy, cancer mortality and long-standing illness (Bauld, Day, & Judge, 2008). The following section identifies the most significant dietary habits contributing to long-term morbidity and mortality, and demonstrates why improving diets should be the priority for all those working in health promotion.

1.1.1 Diet, lifestyle and disease (the modifiable risk factors)

Findings from the UK Government's Foresight programme (Butland et al. 2009) forecast that 60% of men, 40% of women and 25% of children could be clinically obese by 2050, costing the NHS £45.5 billion per year. The UK rise in obesity is a relatively recent occurrence, happening in the main over the last twenty-five years. This rise has coincided with a dynamic societal shift in food culture (the patterning of behaviours around food), gender roles and household disposable incomes (Foster & Lunn, 2007). According to Butland et al. (2009), social change has contributed to this obesity problem and it will need a change in all aspects of society (personal, family, community and national) to solve it. Therefore, as identified by Dubos (1984) some 30 years ago (noted above, as cited in Dowler & Calvert, 1995), the importance of social influences on health are now indisputable.

The National Diet and Nutrition Survey (NDNS, Henderson, 2003) enables researchers and policy makers to compare the changing diet of the nation with nutrition recommendations and requirements in order to assess nutritional adequacy. The survey of adults aged 19 to 64 found that the average consumption of fruit and vegetables among adults in England was less than three portions per day, with women consuming more fruit than men. Men were more likely to consume meat, fats, oils, alcohol: they were also consuming larger quantities of these and other foods compared with women. Younger age groups were more likely to consume confectionary, soft drinks (not low calorie) and alcohol, whereas older groups consumed greater

amounts of breakfast cereals, biscuits, buns, cakes, pastries and fruit pies, fish and vegetables. Of particular interest were the findings on households in receipt of benefits (state benefit, income support and child benefit) who were less likely to consume fruit, fruit juice, breakfast cereal, nuts, cheese, yogurt and fish (discussed further in section 1.2).

Obesity, defined as a BMI of over 25 kg/m² (James, 2008), dramatically increases a person's susceptibility of a number of nutrition related illnesses. Complications of overweight and obesity include glucose intolerance, insulin resistance, hyperlipidaemia, hypertension leading to an increased risk of ischemic heart disease, fatal and non-fatal cardiovascular disease and diabetes (James, 2008). Additionally, being over-weight or obese in childhood, in the short term, can be associated with psycho-social problems such as low self-esteem and depression and, risks a lifetime of over-weight and the resulting complications (Ebbeling, Pawlak, & Ludwig, 2002; Viner & Cole, 2005).

Poor dietary habits are a risk factor for the development of some of the most commonly occurring cancers in the world (World Cancer Research Fund / American Institute for Cancer Research, 2007). In England, the *NHS Cancer Plan* (HDA, 2000) implicated diet in the development of cancers of the colon, rectum, stomach, lung and prostate. After smoking, what people eat is the next biggest contributor to cancer deaths and is responsible for up to a third of all deaths from cancer. Central obesity in women (where the waist and abdomen is surrounded by fat) is implicated in the development of post-

menopausal breast cancer and endometrial cancer. Specific aspects of the diet have also been positively associated with cancer development including low intakes of fruit, vegetables and dietary fibre and, high intakes of energy and red and processed meats (Foster & Lunn, 2007; HDA, 2000).

Fruit and vegetable consumption to the recommended amount has also been associated with stroke risk (He, Nowson, & MacGregor, 2006). In a meta-analysis He, Nowson and MacGregor (2006) report on the protective effects of fruit and vegetables in reducing the risk of stroke and other cardio-vascular diseases and provide strong support for the consumption of five portions of fruit and vegetables per day to cause a major reduction in the risk of strokes.

High blood pressure places individuals at greater risk of cardiovascular disease. The Dietary Approaches to Stop Hypertension (DASH) diet “emphasises fruits, vegetables, and low-fat dairy products, that includes whole grains, poultry, fish, and nuts, contains only small amounts of red meat, sweets, and sugar-containing beverages, and decreased amounts of total and saturated fat and cholesterol” (Sacks et al., 2001, p. 3). When normotensive and hypertensive patients consumed this diet, the trial demonstrated a significant reduction in blood pressure for both groups. When coupled with a low salt version the results were even more pronounced in this American study (Sacks et al., 2001).

As over-weight and obesity are a result of an imbalance between energy intakes over expenditure the impact of physical activity (PA) on health cannot

go unmentioned (WHO, 2012). In conjunction with an optimum diet, a physically active lifestyle has been shown to reduce diabetes risk (type 2), CVD risk, cancer risk and bone health/osteoporosis risk (which has also been correlated with diet) (Phillips, 2004; Miles, 2007).

The evidence presented in the last few paragraphs emphasises the presence of a causal link between poor diet and health, although much research in this field is association based rather causative. A poor quality diet can affect major body systems with chronic life limiting conditions, which are largely preventable with modifications in diet and lifestyle. For this reason, promoting health in order to prevent the onset of these conditions is becoming the focus of all practitioners who work in primary health care (Rao, 2008).

This approach has been maintained in Government policy documents for at least two decades; *Saving Lives: our Healthier Nation* (DoH, 1999) and *Choosing Health: making Healthy Choices Easier* (DoH, 2004) being two examples. The National Service Frameworks for *Coronary Heart Disease* (DoH, 2000) and *Diabetes* (DoH, 2001) also outlined diet and nutrition as crucial elements of Public Health, making promotion of healthy eating a Public Health priority. Nutrition policy is the focus in chapter 2, where these reports are discussed in more detail.

If diet (and by extension, our health) was merely a function of making choices that met physiological need we would long since have abandoned the complicated business of food production in the home. As discussed further

below, food and eating provide a series of signs, signifiers and values that influence our choices much more than anatomical, physiological or mental attributes.

1.2 Inequalities in diet and health

The Alma Ata declaration from the World Health Organisation (WHO, 1978) was first to recognise the holistic approach to tackling health. The declaration of Alma Ata includes the WHO definition of health which states;

...that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO, 1946, p. 100)

The declaration includes the statement that everyone has the right to enjoy the highest attainable standard of health in his or her society; that good health is a human right. Within any country variations in health status do appear between the sexes, age groups and due to chance/luck, health inequalities however, are systematic differences between socio-economic groups. The patterning of health inequalities appear repeatedly in different social groups where rates of mortality and morbidity increase with declining social position.

As such, they are systematic, socially produced and therefore, modifiable and unfair (Whitehead & Dahlgren, 2006).

1.2.1 The health gradient

In the UK there is discrepancy in life length between those in the most affluent local authorities (e.g. Kensington and Chelsea) to those in the most deprived (e.g. Manchester or Blackpool) (DPH, 2008). The report *Our life in the North West* (DPH, 2008) stated that men can expect to live to 75.8 years (some 2.7 years less than the South East and South West regions), whilst women can expect to live to 80.3 years (2.4 years less than the South West). Manchester and Blackpool have the lowest average male life expectancy in England at 73 years, a substantial gap of ten years less than men in Kensington and Chelsea (DPH, 2008). This difference in health when correlated with measures of deprivation is known as the health gradient, defined as a stepwise or linear decrease in health, (not just an extreme group in poor health and the rest in reasonably good health) seen with decreasing socio-economic position (Marmot, 2010; Wilkinson & Pickett, 2009).

The Black Report (DHSS, 1980) is widely regarded as a turning point in the explanation of health inequalities (Townsend & Davidson, 1992; Wilson & Mabhala, 2009). A research working group, commissioned by the then Labour Government (1974 - 1979), examined the relationship between mortality, morbidity and social class in order to assist in the formulation of policy. The group found significant differences in death rates between socio-economic

groups. Mortality rates rose inversely with falling occupational status, for both sexes and all ages. Black originally named this trend the “class gradient” which was observed for most causes of death. Data on morbidity also reflect those of mortality (Townsend & Davidson, 1992). This report established an empirical basis for a health gradient. In essence the working group concluded that responsibility for these health outcomes lay outside of the National Health Service as they were a result of differences in income, employment, environment, education, housing and transport (Townsend & Davidson, 1992). However, the change of Government administration in 1979 led to the report’s findings failing to have the policy impact originally intended (Macintyre, 1997).

Subsequent studies have continued to reinforce the argument presented by *The Black Report*. In *The Black report and beyond: What are the issues?* James, Nelson, Ralph and Leather (1997) identified that those from lower socioeconomic groups suffer from higher rates of nutrition related illness, higher rates of blood pressure and higher levels of coronary heart disease and the occurrence of stroke. In addition, certain forms of cancer and dental caries in children are also higher in low socio-economic groups (Enjary, Tubert-Jeannin, Rodger-Leroni, & Ricordan, 2006). The Whitehall studies on the social determinants of health have also reported strong associations between employment status and mortality, those in the lowest grade employment having a mortality rate from CHD three times higher than those in the highest (Foster & Lunn, 2007).

The *Independent inquiry into inequalities in health Report* by Acheson (1998) goes further to demonstrate that health inequalities were not only present but also possibly widening. Affluent members of society live longer and experience better health than lower socio-economic groups. The report shows how, as a nation across all social groups, we are living longer despite the persistence of health inequalities. However, these added years are not disease free but are characterised by years of chronic illness or disability for those in lower socio-economic groups (Acheson, 1998).

In order to understand the real causes of health inequalities it is important to consider how they are defined and measured. In the UK there are numerous measures of deprivation and social standing. The Office of National Statistics measures social position using the National Statistics Socio-economic Classification (NS-SEC). First used in 2001, it replaces the previous social classifications of socio economic group (SEG) and social class based on occupation (SC) (ONS, 2008). The emphasis here in NS-SEC and on the evidence presented above is on income or employment related inequalities.

Wilson and Pickett (2009), in a cross-cultural comparison from 21 developed countries, observe that people in poverty tend to be less healthy and less happy than the more affluent. However, this ceases to be the case over a certain level of income (\$25, 000 or £15,800 per capita) and some of the richest countries perform worst in relation to health and social problems. The authors conclude that it is the relative income difference within societies, the distance between social groups and the increasing importance of a

hierarchical social structure, coupled with a lack of social mobility that reinforces health inequalities. Existing patterns in the UK point toward this model becoming more deeply characteristic of both recent and predicted change in the UK, resulting in a worsening of health inequalities.

In addition to income related employment scales, a series of other measures have been used to analyse the health gradient. These include ethnicity, gender, housing conditions, educational level, access or ownership of assets, residential area characteristics, number of children under five years per family, number of one parent families and number of changed addresses in the previous year (Acheson, 1998; Jarmin, 1983; Townsend, Phillipmore, & Beatie, 1986). Each of these provides their own health gradient and, in turn, cross-link with other social inequalities.

It can be confidently concluded that some form of deprivation causes health inequalities. People in lower income/occupation grade groups suffer unequally from higher rates of nutrition related disease. However, the number of deprivation indexes and the numerous measures used, suggest the difficulty in defining and measuring inequality and thus, of fully understanding the impact on health. Nevertheless, the fundamental link is clear.

This raises the question therefore of how to address these inequalities if we do not entirely comprehend how they relate to health. Referring back to the WHO declaration (1946), health inequalities are socially produced and are therefore unequally distributed and unfair. If we do not know the real

contributors to inequality they will be remain, despite efforts to tackle them. This point is addressed in the sections below.

1.2.2 Diet related health inequalities

The Low Income Diet and Nutrition Survey (LIDNS) was a large, UK-wide study, commissioned by the Food Standards Agency to look further into the trends seen in the NDNS. UK households were surveyed between November 2003 and January 2005. LIDNS provides information on the dietary habits and nutritional status of low income populations (defined by; receipt of benefits, household composition, car ownership and employment status) (Nelson, Erens, Bates, Church, & Boshier, 2007). Findings from the survey demonstrate that desirable dietary behaviours, from a health perspective, within this group are lacking when it comes to consumption of oily fish, wholemeal bread, fruit and vegetables. Diets of children were worse than adults, with comparisons showing higher consumption of red and processed meats, pizza, burgers and kebabs, chips, fried and roast potatoes, crisps and savoury snacks and non-diet carbonated soft drinks. Low-income groups were more likely to consume fat based spreads and oils, non-diet soft drinks, beef, veal, lamb and pork, pizza, processed meats and whole milk than higher income groups. Compared with two-parent households, children in single adult households obtained a larger proportion of their energy from non-milk extrinsic sugar (NMES). Food energy from NMES was higher in all age groups in LIDNS. Compared with the general population, women had a higher mean BMI and a higher proportion of obesity. Both sexes showed raised

measures of central obesity (there was insufficient data to make any conclusions on childhood obesity). This data confirms the existence of some income and diet related inequalities. However, for many foods, the types and quantities consumed by the low-income population appeared to be similar to those consumed by the general population (as assessed by the NDNS above). The FSA's (2007b) press release, states "the findings suggest that the dietary pattern of people on low incomes is the same as that of the general population, although in some aspects are slightly worse."

Wider research confirms that differences in food choice may not be entirely income related. Key influences on food choice have been recognised as the shopping, preparing and cooking of foods (Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Lang & Caraher, 1998), as have societal influences such as gender (Charles & Kerr, 1988), social class and social relationships (Bottero & Prandy, 2003; Bourdieu, 1984). In recognition of these influences it is not simply enough to presume that the pervasive unhealthy choices of the poor are a result of ignorance or that poor people inevitably buy cheap food (Dowler & Calvert, 1995; Germov & Crotty, 2004). There is a need to examine the possibility of the existence of differences in food choice independent of income. This analysis needs to include the influence of the wider social environment and to examine a more varied and complex picture of health inequalities and their impact on diet-related health. These tasks are undertaken in the next chapter.

1.2.3 Summary

Box 1.1 – Illustration of the terminology “upstream” and “downstream”

(Hubley & Copeman, 2008, p. 16)

"I am standing by the shore of a swiftly flowing river and hear the cry of a drowning man. I jump into the cold waters. I fight against the strong current and force my way to the struggling man. I hold on hard and gradually pull him to shore. I lay him out on the bank and revive him with artificial respiration.

Just when he begins to breathe, I hear another cry for help.

I jump into the cold waters. I fight against the strong current, and swim forcefully to the struggling woman. I grab hold and gradually pull her to shore. I lift her out on the bank beside the man and work to revive her with artificial respiration.

Just when she begins to breathe, I hear another cry for help.

I jump into the cold waters. Fighting again against the strong current, I force my way to the struggling man. I am getting tired, so with great effort I eventually pull him to shore. I lay him out on the bank and try to revive him with artificial respiration.

Just when he begins to breathe, I hear another cry for help.

Near exhaustion, it occurs to me that I'm so busy jumping in, pulling them to shore, applying artificial respiration that I have no time to see

who is upstream pushing them all in...."

A story told by Irving Zola - but is used in an article by John B. McKinlay in "A Case for Refocusing Upstream: The Political Economy of Illness"

McKinlay, J.B. (1981)

People from lower socio-economic groups suffer from higher rates of chronic conditions, conditions that are in many ways diet-related. However, wider research in the area from Charles and Kerr (1988), Dowler and Clavert, (1995) and Caraher and Lang (1998) suggests that food choices are not completely dependent on levels of income and that other possibly more important influences are in action. These are only a few examples from the

wider literature, and it is important to explore and recognise these wider influences so that socially produced health inequalities can be addressed effectively both upstream (policy) and downstream (practice). The following chapter explores these influences, the theoretical thinking behind them and the attempts made in public health policy to address widening health inequalities.

Chapter Two:

Policy and theoretical perspectives on diet, health and inequalities

2.0 Introduction

The previous chapter documented the numerous influences on our health and the multifactoral nature of nutrition-related disease. In recognition of this, we now turn to explore the recent and past policy initiatives that aims to address health inequalities and to the frameworks that underpin them.

Initially, the thesis examines the theoretical models that provide both a primary key to unlock the sociology of food and eating and background to understanding public health policy. Subsequently, historical and contemporary responses to public health issues are examined and their limitations discussed. The chapter then explores the use of community-based initiatives to bring about dietary change, and examines the role of evaluation in assessing their effectiveness. Finally, it debates the need for alternative approaches to dietary health promotion and evaluation that incorporate wider social influences.

2.1 The determinants of health

We can begin to understand the overlapping interaction between the individual and the greater social context, using the “sociological imagination”, a term coined by Mills (1959) (as presented in figure 2.1). Developing the critical sociological approaches of Mills, Willis (1999, as cited in Germov & Williams, 2004) simplified his scheme to suggest that in order to understand an event, behaviour or process, four main dimensions have to be analysed. These can be summarised as: historical experiences; cultural practices and customs (including religious symbolism); wider structural forces beyond our control (the political, economic, environmental); and our ability to question these influences (the critical) (see figure 2.1). Each of the dimensions can be considered as a force, a real influence, just as real as any physical force impinging on human action, providing both constraint and opportunity. Germov and Williams (2004) apply this social analysis to their own study of food and eating. We shall see the appearance of these elements in the policy approaches evaluated below.

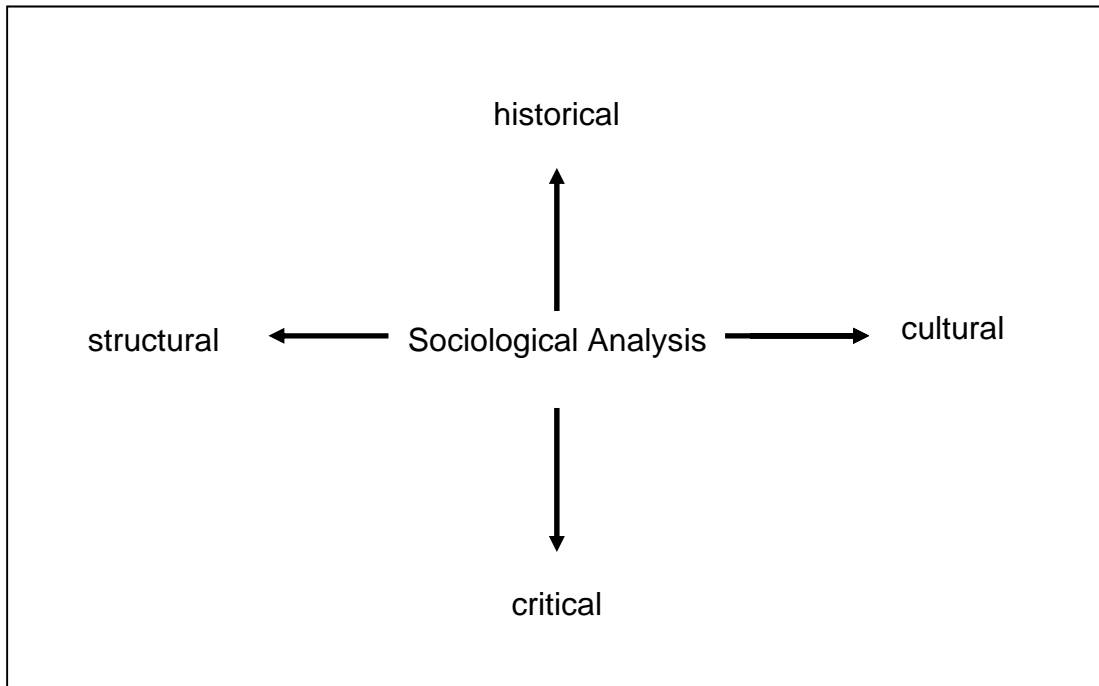


Figure 2.1 The Sociological Imagination template (Germov & Williams, 2004)

Moving forward in history from Mills (1959), a report from the Canadian health minister, *The Lalonde Report* (1974) was an early example of policy documents that provide an insight into the factors associated with disease and where to target action to improve health. *The Lalonde Report* (1974) put forward the “health field concept” demonstrating the various factors that influence health. It proposed four main elements; human biology, environment, lifestyle and healthcare organisation (see Box 2.1).

Box 2.1 The Lalonde Report: Health Field Concept

Human Biology includes all aspects of health that develop as a consequence of the organic makeup of the individual.

The Environment includes the external environment over which the individual has little or no control.

Lifestyle includes the numerous decisions made by individuals which affect their health over which they have control

Healthcare organisation describes the provision of healthcare available to the individual i.e. quantity, quality and organisation of resources

(Tones & Green, 2004)

Dahlgren and Whitehead (1991) also described social influences relating to health. They suggest layers of determinants on health (Figure 2.2). The figure below displays the relationship between health and the physical, social and economic environment. At the centre of the diagram are the unmodifiable characteristics that influence health such as age and gender. Surrounding the centre are layers of influence that do have the potential to be modified, factors such as personal behaviour. The community environment and community influences, factors such as friends and relatives are also shown as wider overarching influences. The model shows all influences as inextricably linked and not independent variables.

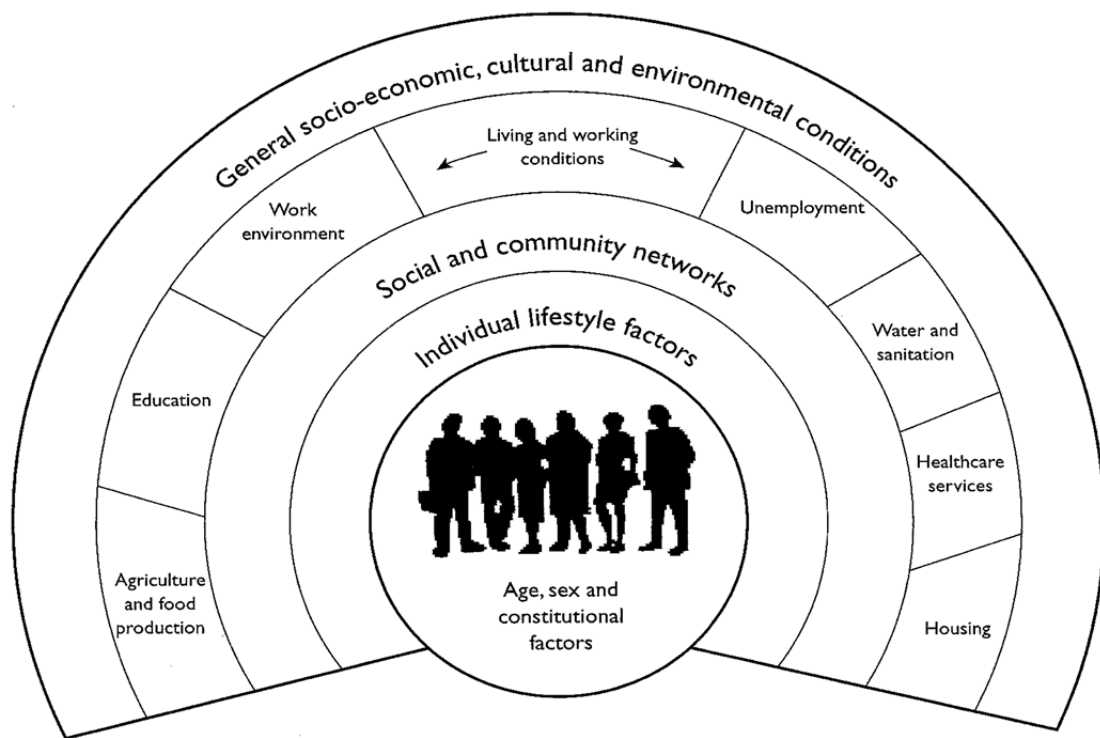


Figure 2.2 The main determinants of health (Dahlgren & Whitehead, 1991)

All three models recognise the impact of wider social and economic influences outside the control of the individual in the construction of food choices. They emphasise that choices are constrained by wider social and structural conditions. Particularly with respect to food, choices are shaped by our cultural background, religious teachings, social interactions, gender roles (independent of biological sex), habitual & historical actions, economics and geographical situation (Germov & Williams, 2004). Acknowledging that individual choices are embedded within social (and physical) surroundings enables further hypotheses on health inequalities to be explored. The analysis of the health gradient in respect of these wider features of influence has been the focus of a number of studies in nutrition. For example; cultural upbringing,

social class and economic circumstances, social and community networks, educational level including nutritional knowledge/awareness and cooking skills and, food access and the built environment (Bottero & Prandy, 2003; Germov & Williams, 2004; Lang & Caraher, 1998). Each of these points is analysed below in relation to its impact on food choices.

The precise causal mechanisms by which we make food choices are neither direct nor fully understood. However, there are clear models available in the social and policy literature that assist our interpretations. The clarification of food choice influence is pivotal in designing public health approaches to address socially produced health inequalities.

2.1.1 Social class circumstance

The decisions we make are as part of society and not always as conscious rational individuals (Caraher & Coveney, 2004; Chadwick, Crawford, & Ly, 2013). Germov and Williams (2004) suggest that our choices are constrained by many structural forces such as social class, gender, ethnicity, historical experience and wider political and economic structures. As described above, therefore, we don't so much "choose" but "select" within these confines (Caraher & Coveney, 2004).

It is important to define social class as distinct from socio-economic group. Socio-economic group is a measure of occupational-based wealth, and social class is a measure of status and capacity. Dubos, (cited by Dowler & Calvert,

1995, p. 759) argues the real measure of health “is the ability of the individual to function in a manner acceptable to himself and to the group of which he is a part”. Thus, it is not necessarily economic constraint but the degree of social power available that enables establishment of social norms (the capacity to make choices in a culturally and socially accepted manner). Social class may therefore, for the purpose of the following argument, will be considered as independent from socio-economic status.

After eating for survival and securing food for tomorrow, Maslow’s theory of human motivation (1943) suggests that the next priority is eating to satisfy the need for security and belongingness. In this function, food becomes a way of meeting love, achieving belongingness and obtaining affection. In agreement with the theory from Dubos (1984, in Dowler & Calvert, 1995), Maslow (1943) states that people seek to overcome feelings of loneliness and alienation, and going against social norms would mean the opposite (Germov & Williams, 2004). If these social norms are detrimental to health then reinforcing them will also have a negative impact and thus, poor health choices accumulate in certain population groups (Bailey, Pain, & Aarvold, 2004).

Food habits easily lend themselves to manipulation for the purposes of social class markers or group identity. Particular lifestyles and taste preferences are used as modes of distinction to symbolise domination over others, to reinforce class identity or to create distinction and separateness from other social groups (Bourdieu, 1984).

Studying social practices in France, Pierre Bourdieu (1984) observed class differences related to food choices. As social standing (independent of income) increases, a lower proportion of the budget is spent on food (Bourdieu, 1984) and, “the proportion spent on heavy fattening foods, which are also cheap – pasta, potatoes, beans, bacon, pork – also declines...whereas an increasing proportion is spent on leaner, lighter (more digestible) non-fattening foods (beef, veal, mutton, lamb and especially fruit and vegetables)” (p. 177). Cross-culturally, different foods associated with the higher classes generally require a certain amount of skill and time to obtain, prepare and cook (Bourdieu, 1984). Examples given include, fish and shellfish, lean cuts of meat, fruit and vegetables, but these are distinctly related to geography as well (Germov & Williams, 2004). Cultural parallels may be drawn nevertheless with the findings from the FSA’s LIDNS (Nelson, 2007), in that diets more generally consumed in the lower socio-economic groups are higher in red and processed meats, total and saturated fats and sugary drinks. Food consumed less by this group were fruits, vegetables and oily fish. It is worth noting that the foods recommended for a healthy lifestyle as stated in the FSA’s EatWell plate (FSA, 2007a), are consistent more so with the intakes of higher social classes than the lower. This therefore, makes it easier for those in the higher social classes to choose more desirable foods and reach these recommendations than those in the lower groups.

Bourdieu (1984) also observes differences in choices in relation to body shape, where members of the working classes demonstrated a “function” as opposed to “form” approach to the body, this compared to the upper classes

who were more concerned about health and beauty. These differences in food choice and appearance are explained as a function of cultural capital: the non-financial social assets that promote social mobility or provide constraints by their absence e.g. group membership, relationships, networks of influence and support. As he explains, “the basis of true difference...is the opposition between the tastes of luxury (freedom) and the tastes of necessity (constraints)” (Bourdieu, 1984, p. 177). Although Bourdieu is subject to criticism (Savage, 2003) with regard the definite dichotomy between the fixed dispositions of classes (particularly as these structures and identities have altered in the ensuing years), his work still forms the basis for much of the analysis on cultural class today (Savage, 2003, Bottero & Prandy, 2003).

Social and lifestyle practices can both draw people together and set them apart. Routine practices confirm group membership in terms of social position or social class. Research from Bottero and Prandy (2003) highlights the importance of significant others on the persistence of unhealthy lifestyles and health inequalities and vice versa. The authors used the patterning of social interactions to both conceptualise and measure inequality in the UK. They found that people sharing a similar social position, (in terms of social class or status group membership), are more likely to interact socially (through friendship, partnership etc.) with members of the same group than with members of other groups (e.g. by class, status, ethnicity, education). Such patterns endure across generations. Their analysis shows that spouses, friends and acquaintances tend to be chosen from those who share a similar lifestyle, as such they were afforded the same resources and rewards and,

relative advantage or disadvantage. In this way, lifestyle factors were reinforced and therefore, so were health inequalities.

According to Bottero and Prandy (2003) their work on social interaction distance holds a “family resemblance” to Bourdieu (1985) and his work on the concept of the *Habitus*. Habitus can be defined as the sum of habits, perceptions, thoughts and actions acquired as part of our cultural make-up (symbols, meanings and cultural goods e.g. music, literature, furniture and food) which in turn reproduce social class structure. In this way Bourdieu (1985) argues that these forms of cultural consumption allow classes to distinguish and assert themselves.

Using a food example from his survey work *Distinction* (Bourdieu, 1984); when motivated by low income it was found that working class men developed a habitus which was more function over fashion. Foods consumed were meaty, filling and symbolized masculinity, and so did not include fish reportedly due to its delicate, less filling, “healthy” nature, involving a certain level of sophistication in the cooking and consumption. Habitus operates in relation to cultural capital and the ability to assert one’s own cultural practices as the most desirable. Bourdieu (1984) claims that each class has its own patterns of shared behaviours, its own habitus, making it possible to identify class based cultural practices which are key to social inequality (Seidman, 2004).

A particularly useful interpretation links food choice with life choices and life chances and the creation of “healthy lifestyles” (Germov & Williams, 2004). Life choices are the decisions people make in the selection of lifestyle habits and life chances are the probability of people realising their life choices; Wilkinson and Pickett (2009 p. 24) articulate this point;

There are perhaps two widespread assumptions as to why people nearer the bottom of society suffer more problems. Either the circumstances people are in cause their problems, or people end up nearer the bottom of society because they are prone to problems that drag them down.

For example, personal experience of particular living and working conditions shape beliefs about diet, health and illness. Frequent illness (more likely in the working classes as explained) also may lead to the belief that one is not able to control one's health, thus life choices are inextricably intertwined with life chances (Germov & Williams, 2004). Either society causes the problems or people are dragged down by problems because they are prone to them through their locations in hierarchies of social inequality (Wilkinson & Pickett, 2009).

The interplay of life choices/habitus/cultural capital both constrains and enables people's decision making processes; what is known as the “structure and agency debate”, central to all sociological study wanting to understanding action (Germov & Williams, 2004). “Structure” refers to us as products of our society and the world around us, which includes economic influence,

multinational influence, changing moral/ethical social values, social institutions and the social groups to which we belong. “Agency” is the potential of individuals to exercise choice and influence over their social world and everyday lives. Habitus is referred to by Savage and Longhurst, (1996) as a means by which the polarities of structural constraint and individual agency can be bridged.

Common criticisms of the diets and food choices of people on low incomes are often ill-informed. While income has been shown to be an important influence on food choice, the evidence suggests that the confines of social structure affects our ability to freely and rationally make decisions and carry out these in spite of outside social forces (Bottero & Prandy, 2003; Bourdieu, 1984; Wilkinson & Pickett, 2009). For this reason social class becomes ever more pertinent for the discussion on food choice.

2.1.2 Gender, mothers and family

The role of mothers in influencing child-health is pivotal; the importance of maternal nutrition, from conception throughout pregnancy leading into breastfeeding and weaning practices has been demonstrated as crucial for providing the infant with essential micronutrients, maintaining birth weight, immunological protection and optimum growth and development (SACN, 2006; WHO, 2003; WHO & FAO, 2003). Barker’s critical period model (Barker, 1992) has demonstrated that maternal and foetal deprivation in the early stages of life strongly correlates with incidence of obesity, CHD, stroke,

type 2 diabetes and raised blood pressure in later life. In addition, the quality of the maternal diet has been correlated with quality of the infant diet (Robinson et al., 2007). For this reason it has also been suggested that the mother's role is responsible for mediating neophobia (refusal of new foods) (Wardle & Cooke, 2008), childhood overweight (Scaglioni, Salvioni, & Galimberti, 2008) and childhood inequalities in health (Belsky, Bell, Bradley, Stallard, & Stewart-Brown, 2007). This evidence provides a clear rationale for the focus on women (at this sensitive stage of development in the future adults life-course) for health policy, nutrition interventions and further research (Graham, 2002).

The development of poor eating behaviours during the early stages of life can set patterns of eating into adulthood (Adamson & Mathers, 2004). Through the socialisation process, where culturally valued norms of behaviour are passed from generation to generation, food practices and mealtimes are used to educate children "at the dinner table". Hence it is said that "sound nutritional practices in childhood is a basis for life-long healthy eating" (Anving & Sallerberg, 2010; Bruce & Yearley, 2006). Mothers still perform the majority of food behaviours in the household (Beardsworth et al., 2002) and so are responsible for establishing food behaviours that last a life time.

Conventionally, biological differences have traditionally been used to explain and reinforce gendered roles and acceptable standards of behaviour: what is accepted behaviour for men is not always acceptable for women. For instance males are 'naturally' aggressive and females 'naturally' passive (Burkitt,

2008). Thus, gender inequality ensues. Despite the changing nature of gender roles and gender relations in the twentieth century, women, largely due to their biological make-up, are still responsible for feeding and nurturing, and therefore clothing and household work (Charles & Kerr, 1988).

Gender encoding of practices also extends to the differences in eating patterns. Women, due to their greater involvement with food, are shown to be more conscious of health aspects of the diet and are more likely to attempt to conform to a “healthy” diet (Beardsworth et al., 2002). Survey evidence from the NDNS show that women attach greater importance to healthy eating and are more likely than men to have made changes in response to official guidelines, reporting higher intakes of fruit and vegetables and dietary fibre and avoiding high-fat foods and limiting salt (Beardsworth et al., 2002; Henderson, Gregory, Irving, & Swan, 2003). In contrast, women are more likely to have altered their diet to lose weight, whereas diet changes are equally likely to be for weight gain as weight loss for individual adult males (Rappoport, Peters, Downey, McCann, & Huff-Corzine, 1995).

Gendered eating that is, the food choices that are influenced by gender, can be traced back to all aspects of food from production to consumption. Most of these behaviours demonstrate differential gender involvement with women usually being responsible for the greater share of food-related activities (Fieldhouse, 1996). For example, research from Beardsworth et al. (2002), shows that the shopping, cooking and preparing of food in 21st century England still remains largely the role of women in the household. Women bear

the main responsibility for deciding what foods to purchased (76.6%), with 67.2% of women claiming food shopping as their responsibility, and the majority (75.8%) of women did most of the food preparation (Beardsworth et al., 2002; Fieldhouse, 1996). Charles and Kerr (1988) also document that, particularly after the arrival of children, women are largely responsible for the regular provision of “proper family meals” (Charles & Kerr, 1988).

Women’s highly involved role in relation to food implies that women exercise power over family food intake and over which foods end up on the family table. They act as “gatekeeper”, and this way impart their own tendencies on to the family. However male and child food preferences are a significant modifier, these also shape food behaviours in the home. To such an extent that women defer to the choices of men and children, which further reinforces subservient social roles (Chadwick, Crawford, & Ly, 2013; Fieldhouse, 1996). Murcott (1983) suggests that whether or not a woman is going to go to the trouble of cooking a ‘proper meal’ depends whether and when her husband is going to be home. In this instance, men are still regarded as the “breadmaker” and women the “homemaker”. Nearly thirty years on from Murcott (1983), the needs of the partner and the child were also seen to dominate over the needs of the mother in research of Swedish parents (Anving & Sellerberg, 2010).

When considering the role of women as gatekeepers in food choice and dietary patterns we inadvertently consider the role of men, children and families. As Charles and Kerr state in the opening to *Women, Food and Families* (1988, p. 1)

This book is about women and food. And because it is about women and food it is also about men and children and families; very specific families – those which contain pre-school age children; families where children are learning to eat and mothers are trying to teach them the rights and wrongs of mealtime behaviour.

The findings from Charles and Kerr (1998), based in the UK city of Manchester, have been criticised by more recent research due to the limited sample of women with young children - a very specific life-stage, and from a specific geographical location in the North of England (Warde & Hetherington, 1994). Nevertheless, these findings still contribute to knowledge on the construction of food choices, and how they are socially produced by being gender related and how they are influenced by the family context. These findings were strongly confirmed more recently in a review of human food choice influences by Chadwick, Crawford and Ly (2013).

Having a greater understanding of the role and relationships within food choice and the social construction of food practices, together with the importance of the family with regard to the nurturing and pleasing role of mothers demonstrate how the issue of food choice is in no way straightforward.

Social class and gender

Social class is also relevant in relation to gender, in that lower social classes are more likely to adhere to these gender roles. In the seminal research from Charles and Kerr (1988), women from lower social classes were more likely to take a greater responsibility for food labour, they also regularly neglect their own needs in preference for meeting the needs of children and partners, so as to please and nurture the family. In comparison, those in the middle classes demonstrated a better division of food responsibility. Income was found to be more influential for lower class groups; by definition low income groups have less money and therefore decisions are more crucial. With greater constraints on income, women reported dissatisfaction in their ability to provide a “proper” meal (a meal that included meat) for the family. Female employment did not appear to influence food roles either, with women in part time and full time employment still taking responsibility for cooking the family meals in the Charles and Kerr Study (1988). However, in contrast to this, Warde and Hetherington (1994) found female employment was the greatest factor for men preparing family meals, but that this is still influenced by class in that employment rates are found to be lower for working class women (Warde and Hetherington, 1994).

It is argued here that in order to fully explain the influences on food choices and therefore to go about addressing them at the regional/local level, the whole social, economic and cultural environment needs to be considered.

2.1.3 Food choice: The 5 A's

The social environment but also the physical environment has a bearing on the extent to which the wider structural environment influences food choice. These physical aspects can be investigated in terms of macro and micro influences on food choice. Expanding on the model by Branca, Nikogosian and Lobstein (2007) microenvironmental influences could include aspects such as getting to the shops and food issues within the home such as access to cooking equipment and storage, our capability to prepare and cook a healthy meal, affording healthy food and the availability of acceptable foods. Macroenvironmental determinants could extend to the wider geography of an area. These can be encompassed within the following headings relating to food choice: awareness, access, affordability, availability and acceptability referred to herein as the “5 A's”.

Awareness

A basic knowledge of nutrition and an awareness of its influence on health is essential for the individuals to know if they exercise “good” or “bad” dietary habits and to instigate change among their family, community or themselves if necessary (Dallongeville, Marecaux, Cottel, Bingham, & Amouyel, 2000). If individuals do believe they have a good diet or are not aware of the risks involved in a poor diet, then change is unlikely to occur (Dibsdall, Lambert, Bobbin, & Frewer, 2002; Van-Dillen, Hiddink, Koelen, Graal, & van-Woerkum, 2008).

The absence of cooking skills has also been raised as an issue in the widening of food choice to healthier options (Caraher, Dixon, Lang, & Carr-Hill, 1998), as has the level of confidence towards cooking (Caraher, Dixon, Lang, & Carr-Hill, 1999). Dowler and Calvert (1995) do not draw a correlation with low income groups and a lack of cooking skills, however a lack of confidence to cook has been seen with low income groups, and in certain methods of cooking (Caraher, Dixon, Lang, & Carr-Hill, 1999; Kennedy & Ling, 1997). Research from Caraher, Dixon, Lang, & Carr-Hill (1999) demonstrated upper class groups were more confident in the use of all cooking techniques but one. The exception was deep fat frying which was the cooking technique that the lowest social class was most confident to use. This was also the finding of a study in Liverpool revealing that individuals with unskilled occupations were significantly more likely to own a deep fat fryer than other groups (Efsthathiou, Grant, & Maxwell, 2004).

A series of studies conducted principally by Barker and Lawrence of women in Southampton found that educational level was a good indicator of diet quality (Barker et al., 2008; Barker, Lawrence, Woadden, Croziera, & Skinner, 2008; Lawrence & Barker, 2009). However, further investigation of the Southampton cohort discovered that educational attainment was only an indication of one of the markers for diet quality and further analysis of the data found links with lower educational attainment and with other influences on food choice. Choices made were considered more to do with issues of control, and loss of control, when making food choices. This feeling of control was related to the

negative influence of partners and children in the household, the amount of involvement with food and also the value placed on their own health in the long term.

Some amount of nutritional knowledge and awareness relating to the impact of poor dietary habits and the impact it has on health is required for people to make changes to their behaviours. However, a level of control and confidence towards diet and cooking appears to create a greater barrier than just knowing what the “right” food choices are to make.

Affordability

The financial cost of a healthy diet becomes more important when money is scarce and a larger proportion of family/household income is spent on food (Charles & Kerr, 1988; Dowler & Calvert, 1995). The desirable food choice recommended by health care professionals that is, the Government Eatwell plate model (FSAa, 2007), is perceived by consumers as more expensive and has actually been found to be more expensive (Darmon & Drewnowski, 2008; Lloyd et al., 2011; Piachaud & Webb, 1996). In this respect, income levels are deemed to be a significant barrier to healthy food choices by these authors.

Findings from a survey conducted by Darmon, Ferguson and Briend (2002) indicated that the budget available to spend on food was negatively associated with diet quality in a French sample. As finances become increasing stretched, energy-dense but nutrient-poor cheaper foods with

components such as cereals, sugars and fats become more significant by quantity, and more expensive nutrient-dense fruits and vegetables less so. The diversity of food and vitamin, mineral and trace element intake was found to increase with income and education level in the diets of a German sample by Thiele, Mensink, and Beitz (2004). This pattern, also seen in the UK, is consistent with dietary habits in other developed countries. A similar trend was apparent across Europe in a pan-European study (De Irala-Estévez et al., 2000) and in an Australian study (Giskes, Turrell, Patterson, & Newman, 2002).

Acceptability

As previously discussed in section 2.1.2 in relation to class and gender, food choices are imbued with meaning. It is useful to explore the differences in food choice as a notion of desirability of choice (a factor that is noted here as rarely recognised in forming health promotion guidelines, no examples were found in the literature). Food insecurity is the lack of access to highly valued foods, in preferred amounts, or in consistent supply (not to be confused with food insufficiency, which remains a source of concern particularly with regards to homelessness, unemployment, the young generation and older people) (Germov & Williams, 2004).

Food choices are passed down from generation to generation and are a construction of the social world around us (Germov & Williams, 2004). It is unlikely that advice conflicting with these social and cultural norms will be

accepted or implemented. For example, in a sample of low income mothers in North Tyneside, North-East England, the decision not to breastfeed was determined by the negative experience and attitudes of family and friends in preference to the advice from health professionals (Bailey, Pain, & Aarvold, 2004). The greatest gains in health can be made when these influences are considered. These considerations have been briefly explored in the public health literature by Tones and Green (2004), where inclusion of individuals in the design of behaviour change intervention proves most effective. These findings are discussed in detail in the following chapter.

Availability and Access

In low income groups, the problems associated with affordability of acceptable foods is further compounded by the issue of food access. Proxy indicators such as, residence in a deprived area, car ownership and limited funds have been correlated with the capacity of low income groups to access inexpensive high quality fresh foods from larger retailers. These groups are consequently more reliant on smaller, more expensive local shops (Beaulac, Kristjansson, & Cummins, 2009; Bodor, Rose, Farley, Swalm, & Scott, 2007; Caraher, Dixon, Lang, & Carr-Hill, 1998; Stafford et al., 2007). This is further compounded by a lack of capacity to bulk buy and take advantage of store promotions (Chung & Myers, 1999).

A review of the literature by Jago, Baranowski and Baranowski (2007) examined the association between the availability of fruit and vegetables and

their consumption. Using the mediating variables model as a basis (“that changes in behaviour occur as a consequence of changes to the variables that impact on that behaviour”) the authors investigated whether the availability of fruit and vegetables (defined by whether foods of interest are present in an environment’ such as in the home, school or work cafeteria) impacts on consumption. The research did suggest that the ready availability of fruit and vegetables had implications for intakes. However, the direction of the association was unclear and a greater availability was seen as a possible proxy indicator. It was concluded that the factors influencing consumption could not be separated from wider mediating variables such as knowledge, self-efficacy, socio-economic status, gender or preference.

Although better availability and access to healthy foods is essential to a healthier diet, the route to changing consumption patterns is considered more complex and requires an approach that tackles the major dietary influences on health such as role expectations, socio-economic status and level of education (Jack et al., 2013).

2.1.4 “The roots of health inequalities run deep” (DoH, 1999b, p. 44)

A diet rich in starchy carbohydrates, fruit, vegetables, fibre, vitamins and minerals (as recommended by the UK Government Eatwell plate model, FSA, 2007a) will reduce the risk of diet-related chronic disease (WHO & FAO, 2003). Ultimately, however, we eat food, not nutrients, and food choices are

governed by the many conflicting and contending social and structural forces influencing our lives.

The discussion so far demonstrates that the barriers and influences pertaining to the food choices of low income individuals and families are a result of their social and economic circumstances, and not a consequence of ignorance or irresponsible choice (although nutritional knowledge and income can partly predict food intake) (Dowler & Calvert, 1995; Chadwick, Crawford, & Ly, 2013).

The literature presented here displays the complexity involved in food choice decisions and the social forces that are involved in the construction of health inequalities. Therefore, to understand food choices we need to consider the social environment around food choice. Addressing nutritional inequalities requires a multifaceted approach utilising interventions that promote health and improve access in a socially acceptable manner.

The following section explores the UK policy context where health is promoted, both historically and in the present. These policies are then examined against public health theoretical perspectives and the effectiveness of methods employed in dietary change now.

2.2. Historical perspectives on public health policy

Public health policies emerge from the identification of “problems”. These then become the priorities for Government that then require a course of action and/or intervention (Parsons, 1995). As will be discussed below, in the case of Public Health, a preventative approach is often proposed.

In order to set modern policy into context, it is of use to look at the historical pathways that have led to public health efforts in the UK today. Modern understandings of public health and welfare in the UK emerge in the context of nineteenth century industrial society and the consequences of the Poor Law Amendment Act of 1834. This period marks both the beginnings of the medicalisation of public health and the emergence of the modern public health movement (Fulton-Phin, 2009) (See Box 2.2).

The medicalisation of public health was strengthened at this time by the work of John Snow (pioneer of epidemiology), who identified an association between the patterns of outbreak of cholera and the Broad Street water pump in central London in 1854 (Webb & Bain, 2011). Other examples of this time include the discovery by Louis Pasteur and the development of germ theory. These findings gave leverage to the medical community to lobby for policy reform on sanitisation, housing and working conditions, food quality, and mark the beginnings of evidence-based practice for public health (Fulton-Phin, 2009). This period of health promotion work exemplifies a scientific approach

focusing on the prevention of disease, where early food and health policy centred on the microbiological causes of infection.

A second strand of concern with diet arose from observation of the poor state of health among Boer War recruits (Baggott, 2000). Consequently policy priorities at the beginning of the twentieth century changed to focus on health improvement for a more effective and competitive population. Consideration of food consumption in relation to public policy thus parallels the development of nutritional science. Together, these two themes demonstrate the emergence of policy and the need for a clear appreciation of causality to deliver that policy effectively. Despite growing evidence of health inequalities in the first half of the twentieth century, little significant reform work was undertaken until the end of the Second World War (Fulton-Phin, 2009; Naido & Wills, 2000).

Box 2.2 Historical timeline of events marking the seminal events of Public Health (adapted from Fulton-Phin, 2009; Naido & Wills, 2000)

1801-1831	Increased urbanisation resulted in huge influx to the cities
1842	Report by Edwin Chadwick on the sanitary condition identifying sanitation as a principal issue.
1848	<i>Public Health Act</i> . Beginning of the modern public health movement Created 'local boards of health' - authorities responsible for sanitary reform.
1854	John Snow, outbreak of cholera and the Broad Street water pump
1864	Development of germ theory by Louis Pasteur.
1872	<i>Local Government Act</i> . Established Medical Health Officers.
1875	<i>Public Health Act</i> . Consolidation of all previous legislation and the provision of public health services and hospitals.
1900	Rejection on health grounds of 28 per cent of army volunteers for the Boer War
1917-1921	Introduction and end of food rationing during WW1
1906-7	<i>The Education Act</i> . The provision of school meals and the regular medical examinations of children.
1940-1954	Introduction and end of food rationing during WW2
1948	Formation of the NHS.
1980	<i>The Black Report: Inequalities in health</i>
1985-6	WHO “ <i>Health for All</i> ” programme and publishes Ottawa charter
1997	Election of the “New Labour” Government
1998	<i>The Acheson Report: Independent inquiry into inequalities in health</i>
2004	<i>Choosing Health: Making health choices easier</i>

2.3 Contemporary policy interventions in Public Health

2.3.1 The new public health

The establishment of the NHS in 1948 represented a move to collective social responsibility; however, its reorganisation in the 1970's changed the direction of responsibility toward the individual. The ideology behind public health policy in the latter part of the twentieth century continued to emphasise the responsibility of the individual for their health, supported by information and advice provided by health professionals (Naido & Wills, 2000). Public health departments remained at the centre of medical care (Fulton-Phin, 2009). Two factors did briefly combine to rekindle the importance of public health policy. First, recognition of rising levels of chronic conditions in the UK such as cancer and coronary heart disease, and second, the Report of the Working Group on Inequalities in Health (also known as *The Black Report* after chairman Sir Douglas Black, President of the Royal College of Physicians) (Townsend & Davidson, 1980). However, under the neo-liberal ideology of the Thatcher administration, which sought to minimise the impact of *The Black Report*, policy emphasised the private and individual responsibility as opposed to the collective, social responsibility seen in the past (Lovell, 2009). The new individualised approach is exemplified in the policy document *Prevention and Health: avoiding heart attacks* (DHSS, 1981) which advocates the use of media marketing campaigns for the improvement of dietary habits and smoking reduction.

During the 1980's and early 90's individualist ideology prevailed (Dowler & Calvert, 1995). 'Informed consumer choice' was presented as the key to the prevention of disease. Dowler and Calvert (1995) provide a powerful counter-argument to this approach to policy. In their investigation of the food choices of lone parent families the authors contest the accepted and dominant political thinking that people were choosing to "behave badly" out of defiance or ignorance, finding instead that study participants had the same nutritional knowledge and aspirations as the rest of the population, attitudes which nutritional education campaigns did little to change. Instead, circumstances limited the possibility of acting in accordance with their understanding of best practice.

This renewed interest of UK Government in health education campaigns and preventative health services was less a reflection of the new knowledge behind *The Black Report*, but more associated with a "capitalist" rise and retreat from state spending on public services wherever possible. The educational approach was not substantiated by evidence (as we have seen in the previous chapter) and in retrospect it is clear to see, that these public health policy decisions were more to do with a politicised, vote-winning strategy than enabling the population to make healthier life choices.

The *Independent Inquiry into Health Inequalities Report* under the chairmanship of Sir Donald Acheson, (known informally as the Acheson Report, 1998), was commissioned in response to perceived failures in public health during the 1970's and 80's. *The Acheson Report* (1998) marked

another decisive shift that made public health a priority for local authorities. The report reiterated the health inequalities identified by *The Black Report* and also the recommendations to close the gap between the rich and the poor and to prioritise “at risk” groups such as women and lone parents. This did not however mean public health was at the forefront of national policy (Baggott, 2000). The report was criticised by Black, Morris, Smith and Townsend (1999) for its lack of integrated thinking and lack of a concerted approach at a national Government level. The authors argued “these general recommendations have to be turned into exact operational elements of a bold and integrated national plan” (p. 726).

Internationally, the wider social influences on health were recognised in policy. Specifically, the World Health Organisation (WHO) *Health for All principles* reaffirmed at the conferences of Alma Ata (WHO, 1978) and Ottawa (WHO, 1986) recommended a holistic view of health, and integrated approaches contributing to the progressive improvement in health for the most needy worldwide. The Health Field concept (see Box 2.1) of the Canadian health minister recognised the wider environment, lifestyle and healthcare as influences on health. These, in conjunction with approaches taking place in the United States (US) such as the *Wisewoman* programme established in 1993 to support uninsured women from deprived populations in terms of chronic disease risk factors (Labarthe, 2007) highlights how the UK failed to recognise the importance of preventative, pre-emptive healthcare.

Public health policy in the second half of the twentieth century, compared with the ground and improvements made in the nineteenth 19th century and early to mid 1900's, was not so distinct and it was not a priority for successive UK Governments. Policy was not integrated and the responsibility of delivering it still remained primarily with medical professionals as one of their roles (Baggott, 2000). Public health policy of the 21st century introduced by the Blair Government post-1997 meant changes again in policy.

2.4 Interpretation and evaluation of policy in recent past (1997-2010)

Blair's New Labour emphasised a 'third way' between state provision and an unfettered free-market (Giddens, 2000). Under the Blair administration in the UK, public health policy (including food and health policy) saw a shift toward more integrated approaches that recognised wider social forces such as the home and community environment. It is therefore wholly appropriate to explore these, the nature of implementation and the evidence of their effectiveness in this section.

The Government White Paper; *Saving Lives; our Healthier Nation* (DoH, 1999b, p. 2) states:

We are putting forward the first comprehensive Government plan focused on the main killers: cancer, coronary heart disease and stroke, accidents, mental illness.

The White Paper stressed health improvement as a “key role for the NHS”, improving the health of all and the health of the worst-off in particular. This White Paper was followed up by a series of National Service Frameworks (for example, those on coronary heart disease (DoH, 2000), diabetes (DoH, 2001) and mental health (DoH, 1999a), to guide development of health improvement programmes. These policies accompanied the introduction of Health Action Zones (which emphasised integrated approaches to tackling health inequalities at a local level) and also Healthy Living Centres (community based health promotion initiatives funded partly by the National Lottery’s New Opportunities Fund). These Centres aimed to tackle the “social, economic and environmental factors inhibiting good health” (Baggott, 2000). The aims and objectives of these White Paper and policy documents demonstrate a more holistic understanding of health with an appreciation for the wider social determinants of health. These policies also consider a ‘joined-up’, integrated approach to tackle chronic health conditions (cancer, coronary heart disease and stroke, accidents and mental illness) with combinations of upstream and downstream policies (see Box 1.1). From 1997, we can see a definite policy shift towards health improvement initiatives that incorporate integrated approaches to health service delivery.

Banker and policy advisor Derek Wanless was commissioned by the Labour Government to examine future health trends and the resources required to improve the performance of the NHS both within the UK and, to close the gap in health care internationally. In 2002 the first of the Wanless’ reports for the UK Government was published; *Securing our future health: taking a long-term*

view. Within this report he published his “fully engaged” scenario (Wanless, 2002). Scenarios were used by Wanless “to build an understanding of what the impact of different possible futures [financial] might be...to assess the pressures on the organisations and understand any uncertainties for the future”. There were three key scenarios, the fully engaged scenario was the least costly and most productive in terms of life expectancy and the least amount of time spent in ill-health, to be achieved by a dramatic improvement in the public's engagement and ownership in health. Wanless (2002) described the fully engaged scenario:

Levels of public engagement in relation to their health are high:
life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care (Wanless, 2002, p.35).

This scenario models a shift in the level of public engagement in health and proposes that the more people engage with and take responsibility for their health, the more they utilise preventative or primary health care services, the better health will be, and therefore the less costly healthcare will be to the NHS.

In his second report for the Government, Wanless (2004) clearly defines public health, the roles and responsibilities of public health policy that incorporates a broad approach to public health:

Public Health is the science and art of prevention of disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private communities and individuals. (Wanless, 2004, p. 27)

This second report; *Securing good health for the whole population* (Wanless, 2004) looked at how consistent public health policy was with the aspects of the fully engaged scenario. Wanless (2004) acknowledged that ultimately individuals were responsible for their own and their children's health however, people were failing to make the right decisions. Wanless recommended that public services would have to be more informative and show a greater recognition of the many engrained social habits and, socio-economic health inequalities inhibiting healthy lifestyles. This would require the involvement from "Government – national and local, media, businesses, society at large, families and the voluntary and community sector" (p. 4). Wanless himself describes it as an "optimistic" scenario which required more evidence on the most effective and robust approaches for its implement. Therefore, knowing what influences health choices and what works in terms of changing these becomes ever more important.

The fully engaged scenario is underpinned and emphasised in the White Paper, *Choosing Health; making healthy choices easier* (DoH, 2004). The White Paper recognised that health and lifestyle choices are influenced by where we live, our personal circumstances and the relationships we have with the people around us. In response to Wanless, *Choosing Health* emphasises

enabling people to change their lifestyles by supporting community action; that a community with good access to services, cohesion and strong partnerships with health services and community organisations provides an environment for people to make healthy choices. Public health nutrition (PHN) policy forms a major part of the Choosing Health strategy.

The following White Paper, *Our Health, Our Care, Our Say* (DoH, 2006) proposed a shift in service development and delivery to allow people to make their own decisions regarding their health care that is, what is termed a “bottom-up” approach. The policy emphasises community empowerment, early intervention, and improved access to primary health care particularly for underserved and deprived members of the community. The policy aims to modify service provision in order to provide:

...high quality support meeting people’s aspirations for independence and greater control over their lives, making services flexible and responsive to individual needs (DoH, 2006, p5).

Our Health, Our Care, Our Say (2006) emphasises the importance of primary care to enable people to become empowered toward their health. This is also the case in the review of NHS reform by Lord Darzi (pioneer surgeon and health minister), which reaffirms the responsibility of primary care to promote health via a multi-agency approach to provide comprehensive preventative services (Darzi, 2008) and is therefore, referring to the provision of services that fight against the many forces impacting on health.

This era in public health policy recognised the importance of early intervention and the impact of a “healthy start” for life long adult health. The *Every Child Matters* (2003) green paper was supported by reforms in the Children Act 2004 and addresses all aspects of child health from social services reforms to Surestart Children’s Centres (DfCSF, 2003).

The white paper *Healthy Weight, Healthy Lives* (DoH & DCSF, 2008) focuses specifically on children with a multifaceted strategy that aims to “reverse the rising tide of obesity and overweight in the population by ensuring that all individuals are able to maintain a healthy weight”. It details the involvement of schools in the National Healthy Schools programme, for providing healthy meals, cookery lessons, healthy lunch box guidance, greater opportunities for physical activity and their involvement in the National Child Measurement Programme. It describes the role of parents and providing the appropriate information and education for parents and investment in social marketing. At a legislative level the policy proposes action in the food industry and incentives for better health at work, at a structural level, cycle lanes, walking initiatives and local sport programmes are proposed.

The *Healthy Lives, Healthy People* (DoH, 2011) report commissioned by the Labour Government provides details of an integrated public health system that provides “new opportunities for community engagement and to develop holistic solutions to health and wellbeing embracing the full range of local services (e.g. health, housing, leisure, planning, transport, employment and

social care)” (p. 4). The latest reforms planned for the public health system again acknowledge the need for an integrated approach that tackles the wider determinants of health. However, little detail is given on how best to do this and the report states that further consultation is need on the best approaches that achieve improvements in public health outcomes. Therefore, essentially providing choice and funding to local authorities without informed support on how best to do this.

These numerous policies and strategy recommendations are reaffirmed in the Skills and Career Framework (n.d.) for all public health professionals (including nutritionists and dietitians) from the Sector Skills Council for Health. The framework details the key areas of development for public health professionals (see Box 2.3). The framework corresponds with levels within the NHS Knowledge and Skills Framework, is supported by the Nutrition Society (now Association for Nutritionists) and informed the current British Dietetic Association curriculum framework for dietitians.

Box 2.3 The Public Health Skills and Career Framework

- The public health skills and career framework is a tool for describing the skills and knowledge needed across all groups, domains and levels of the public health workforce.
- A mechanism that facilitates collaboration and coherence across this diverse workforce, in order to maximise its collective contribution and underpin the influence of public health in the UK.
- To ensure rigour and consistency in skills, competence and knowledge at all levels, regardless of professional background, and by enabling flexible public health career progression.

(Public Health Skills and Career Framework, n.d.)

This considerable list of policy documents a number of rapid changes to public health policy in a relatively short period of time. However, despite what appeared to be Governments going to great lengths to achieve a more informed, integrated public health service, policies to address health inequality have been criticised for their lack of cohesion (Caraher & Dowler, 2007) and accordance with the experiences of lay individuals (Attree, 2006). They have also been criticised for a lack of robust approaches for their implementation that actually tackle the wider determinants of health “on the ground” (Wanless, 2004).

Critical analysis of policy relating to dietary inequalities reveals a continued stubbornness on the part of Government to move away from individualism,

even while professing to tackle wider social and structural forces impacting on health (Attree, 2006). Causes of diet-related health inequalities are still presented as the result of a deficiency in knowledge and the (un)healthy attitudes of low-income groups, resulting in undesirable behaviours. Attree (2006), from the Institute for Health Research at Lancaster University, also criticised public health nutrition policy in the UK as lacking in the appreciation of both the psychosocial and cultural aspects of food consumption, and of the desire of individuals to conform to social norms of behaviour. Findings from the Kings Fund (a charitable organisation working to improve health services in the UK) suggest a disconnection between government and public perceptions of strategies to address health inequalities. The Kings Fund showed that individuals have a generally good understanding of what contributes to health (Public Attitudes to Public Health, 2004 cited in Attree, 2006).

The policies presented in this chapter were implemented without connecting with practitioners and with little knowledge of how they were going to be implemented “on the ground” (Barron et al., 2009). Public health policies today still hold the individual (as conscious, rational agents) responsible for change as opposed to a balanced approach that recognises the importance of the individual but does not exclude the reality and impact of these wider social forces (Dowler & Caraher, 2003). Inadequacies in policy, not just to acknowledge but also to provide appropriate approaches that address the underlying causes of health inequality have significant implications for their effectiveness (Barron et al., 2009). In the current state of health policy, it is

likely that gaps in provision could occur in delivery and, due to the limits of Primary Care Trusts, especially in relation to non-congruent local authority boundaries, implementation is likely to be patchy, dependent and localised.

The conventional approaches “on the ground” to tackle the social production of health inequalities will fail if they do not consider the bigger picture of influence on health. This gap between policy and the provision of appropriate approaches in practice is at the root of tackling health inequalities.

2.5 Public Health Nutrition strategies for change

Choosing Health (DoH, 2004) and White Papers published prior to this (DoH, 1999b), inform the public health nutrition strategy on diet. These policies stress the need to address diet as one of the main causes of health inequalities, with approaches aimed at the prevention in order to reduce the risk of diet related chronic conditions and to reduce the cost burden these place on health services (Wanless, 2004). The community food initiative is repeatedly seen as the popular solution to address the barriers to a healthy diet and tackle diet-related health inequalities. Particularly, those that provide nutritional advice and the opportunity to plan and prepare meals (Rees, Hinds, Dickson, O'Mara-Eves, & Thomas, 2012; Dowler & Caraher, 2003).

2.5.1 Community based food and health initiatives

A greater understanding from the academic research world of the factors that influence eating behaviour and the context in which food consumption takes place (already described), has meant an emphasis in PHN policy on the use of strategies and policies that have a more holistic approach to diet. Policies that have the ability to tackle the numerous factors affecting food choice, that are responsive to individual and community needs, and that target those in low socio-economic groups or living in disadvantaged areas (Buttriss et al., 2004a; Buttriss et al., 2004b; DoH, 2006). In order to achieve this, there has been an increase in the presence of community food projects at a local level (Morón, 2006, Rees, Hinds, Dickson, O'mara-eves, & Thomas, 2012), particularly for their potential to provide culturally sensitive and appropriate advice (Kennedy, Ubido, Elhassan, Price, & Stepton, 1999; Garcia, Vargas, lam, Smith, & Parrett, 2013).

In their examination of the potential role for community food initiatives, Caraher and Dowler (2003) characterised them as:

...initiatives which have in common: food (its production, preparation or consumption), local involvement (management, delivery, paid/unpaid workers) and state support (funding, space, professional input, transport, equipment)...it ranges from practical sessions on cooking, through food co-operatives or transport schemes, community cafés and gardening clubs, to breakfast clubs in schools...oriented to personal change,

some also attempt to address structural and access problems faced by low-income households. (Dowler & Caraher, 2003, p. 53).

As funding bodies in the public and voluntary sectors invest in community initiatives, there is a call for the projects to demonstrate accountability and value for money through the monitoring and evaluating of all aspects of functioning. The field of nutrition is no exception to that of wider public health initiatives. Where resources are increasingly overstretched, service provision has to be effective and expenditure must be justifiable (Robson, 2000; Smith & Phillips, 2002). Despite this, the body of evidence that demonstrates the effectiveness of community food initiatives is particularly small and inconclusive (Mitchie, Jochelson, Markham, & Bridle, 2008; Rees, Hinds, Dickson, O'Mara-Eves, & Thomas, 2012; Garcia, Vargas, Iam, Smith, Parrett, & 2013). For this reason, the House of Commons Health Select Committee on Health Inequalities (Barron et al., 2009) which examined the political strategies which aimed to tackle health inequalities, described the use of community projects as based on guessimates, rather than evidence-based practice. In light of this, they described the implementation of them as "large-scale experimentation" and as "unethical". The findings of the Health Select Committee contribute to the argument that policy initiatives are introduced with little evidence of their effectiveness.

There a number of reasons why community food initiatives lack an evidence-base that demonstrates their effectiveness to tackle diet-related health

inequalities. Firstly, their wide remit, varied approach and multifaceted nature with aims to address a range of barriers to a healthy diet (access, knowledge, skills, confidence, behaviours) makes them complex to evaluate through conventional (positivistic) evaluation techniques, and therefore provides methodological challenges. The specificity of the approaches taken, means the generalisability of evaluation findings is also low (evaluation is further explored in chapter 2.7) (McGlone, Dallison, & Caraher, 2005; MRC, 2000; Wrieden et al., 2007).

Secondly, the short term nature of their implementation results in an inability to demonstrate sustained behaviour change. Instead, they collect data on immediate outcomes, and outcome indicators for predicting longer term outcomes. This is further exacerbated by the challenges projects face from fixed-term, inconsistent funding strategies and projects having to constantly “reinvent themselves” (Dowler & Caraher, 2003; McGlone, Dallison, & Caraher, 2005; Garcia, Vargas, Iam, Smith, & Parrett, 2013).

Thirdly, food projects tend to focus on the individual and individual change such as improving cooking skills or food access, as opposed to addressing the upstream determinants of food choice, which they are well placed to attempt (Dowler & Caraher, 2003). Determinants such as confidence building, capacity building, reducing social isolation, giving people a sense of worth and well-being, empowering them, and raising levels of skills, enabling people to feel more in control and exercise choice within their environment (issues that are further explored in the sections to follow) (Valentine, Longbottom,

Wrieden, Anderson, & Dowler, 2002; Garcia, Vargas, Iam, Smith, & Parrett, 2013).

Finally, people attend food projects for different reasons. People may attend to meet others, have fun and spend time with their children, whilst the project will be interested in whether they have had an impact on healthy eating behaviours, cooking skills or caused the reduction in the risks of heart attacks for example. Therefore, client and project may have strongly different criteria for 'success'. Project perspectives view projects as an end point enabling the meeting of targets, client perspectives view them as a beginning point, from which to move forward (Dowler & Caraher, 2003).

The failure of the Health Select Committee (Barron et al., 2009) to recognise the worth of community food projects thus far in the UK can be attributed to the number of limitations identified above. Namely, the limitations of the policy by which interventions are implemented, the non evidenced-based approach to their implementation, the complexity of approaches to their evaluation, and the conflict of priorities within public health services that is, a "tick box" culture of short term "fixes" to some of the individual barriers of food choice. Therefore, changing the theory behind the approach and the evaluation of these projects may demonstrate their worth more effectively (Anderson, 2007).

Two key questions have been raised from this examination of community food initiatives: firstly, are the most appropriate approaches fundamental to the

improvement of health inequalities being used? Secondly, are the most appropriate outcome measures and approaches to evaluate these outcomes being used, so that they are of use to health policy and professional practice?

Although the reality of social forces are recognised as important at institutional/report level, intervention of us at the micro level tends to leave these behind and construct the individual as a fully autonomous agent, not exploring the reality of how these forces are felt and expressed in the lives of individuals. An examination of community food initiatives through the educational model of community development could provide the evidence needed to support the limitations in policy, inform the evidence base for the continued use of these projects and practice “on the ground”, and further add to the wider debate on the realities of diet related health inequalities.

2.6 Community Development working

Community development (CD) theory of empowerment and engagement could guide us to an alternative in terms of what strategies are used in dietary change and how effectiveness is measured. Firstly, the “community” concept must be defined, the CD approach explained, and implementation strategies discussed. Secondly, the issue of place and how people interact with the space around them is examined and finally, the approaches used to bring about community change are discussed.

2.6.1 The language of “community”

Community, is described as “one of the most important yet ill-defined concepts in the social sciences” (Fremaux, 2005, p. 265). Community has been used as a basis for extensive Government intervention where it has been identified as a place for action, to empower citizens and as a powerful force for promoting and protecting health (DoH, 2004 & 2006; Department of Communities and Neighbourhoods, 2008). As the following discussion exemplifies, defining the community concept has been the focus of a long standing debate among social scientists, mainly due to its confused meaning and conflicted use (see for example Kumar, 2005).

The observations of Ferdinand Tönnies made during the late 19th century industrial revolution are often used to characterise community (Bennett & Watson, 2002; Bruce & Yearley, 2006; Jary & Jary, 1991). Tönnies noted a change in human relationships when areas expanded in size, became more industrialised in terms of transport and employment and inhabited a more diverse demographic. Tönnies recognised a shift from a traditional community, referred to as *Gemeinschaft*, representing themes of intimacy, durability, facilitation, cooperation, shared culture and mutual support, to *Gelleschaft*; meaning destruction, industrialisation and urbanisation, leading to anonymity, impersonality, fleeting contractual relationships and, ineffective broken communities with a lack of authority (Bennett & Watson, 2002).

Tönnies' "romanticised" view of community, defined by community spirit or community feeling, although contested (Young & Willmott, 1957), are still the common-sense views of community and highly desirable characteristics (Naido & Wills, 2000). As such, this concept is a perfect vehicle for use in policy documents today. However, this does have implications for the implementation of policy.

Frameaux (2005) acknowledges this contestation and also the connotation of community as the answer to (and for that matter the cause of) deprivation, dysfunction and social exclusion. Frameaux observes that where community is the solution we see the emergence of community lead projects, of "grass-roots" and "bottom-up" initiatives and the beginnings of community development projects. The difficulty here being the lack of a defined community for the policy invoking "community involvement", thus for community initiatives to work, this notion of community needs to exist or have existed. This is exemplified in the following excerpt;

These initiatives, take as a grounding view the pre-existence of communities as local entities, encompassing latent community 'values' that suitably devised Government programmes would revive...Indeed, to his own question 'who decides where "the community" ends and others begin?' (Giddens, 1998, p. 85), Giddens provides the telling answer: 'Government must adjudicate on this and other difficult questions' (Giddens, 1998, p. 85 cited in Fremeaux, 2005, p. 271)

To conclude, community is essentially a political concept. Without a clear understanding, the connection with people and their environment will be unhinged, and growth and development from a policy standpoint, particularly in the most marginalised groups, will be constrained rather than promoted. This was seen in research from the Joseph Roundtree Foundation where it was only a small social network of the community that repeatedly got involved in community governance, having the resulting effect of further excluding those not involved (Skidmore, Bound, & Lownsbroug, 2006).

Jordan (2002) makes the observation that communities do exist but in different forms. He defines community by using people with similar identities or ideologies. Jordan (2002) goes further to suggest that it is not just the group themselves but the similarities between the “everyday, community and space” that produce a community. For example, people do not experience space the same, therefore community is a construction of the groups that we belong, the everyday activities we perform and the space where it all occurs. The examination of a 1950's inner-city London borough community by Young and Willmott (1957) is used by Jordan (2002) to illustrate the connection between everyday life activities, the characteristics of the people who perform these actions and the space in which these actions take place to explain the community concept, described below.

Young and Willmot (1957) follow the movement of residents from a built-up inner city area (Bethnal Green) to a newly built suburb (given the fictional name of Greenleigh), they used qualitative interviewing to record the changes

in the nature of community. Community in Bethnal Green manifests itself as a network of kinship that is, the relationships with relatives and friends, the close proximity of these networks reinforced by the physical structure of houses, pubs, jobs which are linked together by everyday activities such as shopping and socialising. In the move to Greenleigh the geography of space changes; large open spaces, fewer houses, shops and pubs per area and a greater distance between places causes fractioning in the community, space and the everyday (Jordan, 2002). This demonstrates that a community is a construction of the groups we belong, the activities we perform and the place it occurs.

The New Towns Act 1946 was the subject of Young and Willmot's research (1957). The New Towns Act 1946 aimed to build economically and socially successful communities in response to war-damaged inner city areas and an increasing UK population. Both expanded towns and whole new settlements were intended to provide more and better quality housing, employment and living spaces. By 1970, the list of New Towns included Basildon, Bracknell, Central Lancashire (Preston, Chorley & Leyland), Corby, Crawley, Harlow, Hemel Hempstead, Milton Keynes, Northampton, Peterborough, Redditch, Runcorn, Skelmersdale, Stevenage, Telford, Warrington, Washington and Welwyn and Hatfield (New Towns Act, 1946).

Community may not be present in the same sense that overriding Government reports suggest, however the evidence above proposes that communities exist by virtue of similar location, situation and every-day

activities. For the context of this research, the geographical locality is (the New Town of) Skelmersdale, West Lancashire. Under examination is a community food initiative in Skelmersdale that aimed to improve food access, availability, nutritional awareness as a means of securing community development. This locality provides a unique opportunity for an investigation into the effects of a community food initiative, within a specific group within the community (mothers of young children) at a significant point in the life stage, in relation to their ability to promote action, empower and protect health.

2.6.2 Place

The issue of “place” as a definition of community is also politicised. Place is used by Government and other policy makers such as local authorities to distinguish between areas of disadvantage for example defining them areas of high or low deprivation, and furthermore as “obesogenic environments”, “food deserts” or for providing an abundance of “good” and “poor” access to food (Acheson, 1998; Marmot, 2010). Place is the preoccupation of most Government policy relating to diet, health and inequalities (Cummins & Macintyre, 2002), for example, the identification of the close association between place of residence and links with increased morbidity and mortality, not seen more so than in the well documented north/south divide in health inequalities or more specifically the north-west/south-east divide (DPH, 2008). This demonstrates that, community and within this, “place”, are understood to be associated less with physical geographies and more with social characteristics and income inequality.

This examination of community and place leaves a number of questions for further investigation. Firstly, of whether the experience of place is the same as identified in policy that is, do people feel the physical environment around them is inhibitive to healthy food choices. Secondly, whether this experience is the same for all groups of the population or are some groups affected by place more than others that is, those without employment, transport or social support networks. Thirdly, providing analysis through the perspective of community development, can a community food project change the way people feel and interact with the place around them, and therefore have implications for accessing a healthy diet. These points will be further examined in the following sections.

2.6.3 The Community Development model

Community development (CD) is an educational model derived from the work of Brazilian educationalist Paulo Freire (1970). The model was first used to develop literacy levels in order to develop the skills of politically oppressed groups in the Brazilian state of Pernambuco. Literacy levels were a prerequisite for voting in local elections and improving literacy levels afforded citizens control over their situation and therefore better equipped to meet their needs. Freire taught with an in depth understanding of his subject's world so as to educate within the context of their lives (Freudenberg et al., 1994; Kane, 2001).

CD is defined as “a process that stresses working with people as they define their own goals, mobilise resources and develop action plans for addressing problems they have collectively identified” (Hogg & Hanley, 2008, p. 22). In doing so CD principles seek to empower, engage and increase the capacity of individuals through promoting participation and joint working, usually with marginalised and disadvantaged communities. The CD model aims to bring about social change by providing a sense of influence, ownership or control over policy implementation (FCDL, 2001; PAULO, 2003). CD outcomes are said to be gained through local participation for solving local problems (Chamberlain, 1993) by utilising skilled, empowered members of the community (CD practitioners). From this beginning the principle has been widened to include a range of educational developments for inclusive citizenship. Tones and Green (2004) propose that if community action that is, the mobilisation of disadvantaged or powerless groups within community (Jary & Jary, 1991), is at the heart of public health nutrition, then individuals will be more likely to adopt desired changes. Involving people in the decision-making process means changes are more likely to be effective than if an external source was to identify a problem and propose a solution onto them. With the use of CD underpinning a community intervention, it is anticipated that individuals and communities will become more engaged, increase health problem solving capacity, and be empowered with respect to their health and therefore, produce the desired outcomes with regard to the reduction in health inequalities and related illness.

Smock (2004) provides an account of community organising and social change from a US perspective. In line with Freire, Smock also agrees that due to disparities in income, social status and resources the most educated and wealthy are afforded the most control politically and socially. This results in the exclusion of the disadvantaged, which ultimately brings about disengaged, disenfranchised communities. For a truly democratic society, the author states that mechanisms must be in place so the “ordinary person” can have control over the economic and social issues influencing them. Smock (2004) identifies five models of community action for achieving social change, which have a number of common themes with CD. For example; building individual capacity by developing the skills, knowledge and self-efficacy of residents; building community capacity by developing community and social networks; also, participation, leadership and agreed action; community organising, a process that aims to “build residents skills as public actors and engage them in collective action to achieve common goals” (Smock, 2004, p. 5).

International public health policy recognised the gains that can be made with a CD approach to community food interventions. The Jakarta declaration stressed the need for people to be at the centre of the decision making process for health promotion to be effective (WHO, 1997). UK Government, since the election of the New Labour Government in 1997, reflected these international decisions. CD principles were endorsed by Government public health strategies that promote community initiatives as place for individuals to take control, be empowered and enable its participants to change, principles that are underpinned in the Wanless Report (DoH, 2004, 2006, Wanless

2004). Since then, CD principles have filtered down into the aims and objectives of community based initiatives “on the ground” (CDF, 2006)

Principles of CD are a relatively new concept in the field of public health nutrition (Dowler, 2008). Health is currently promoted, largely, in a biomedical model (health being the absence of disease rather than a state of complete physical and mental wellbeing) (Naidoo & Wills, 2009). However, the role of the public health nutritionist (identified by the Public Health Skills and Career Framework (Rao, 2008), involves being a core nutritional scientist. However, the factors that were identified as being most critical to the success of their work were; partnership working, an ability to develop broader community skills, to draw in on the social sciences, understanding the concepts of community and to incorporate the broader issues relating to health (Hughes, 2003). Here, the Skills and Career Framework for public health practitioners uses the principles of CD to bring about change in diets.

Although CD has received little attention, Baillie, Bjarnhalt, Gruber and Hughes (2009) acknowledge the emerging references towards capacity building for use in PHN practice. The authors define capacity and provide a framework for incorporating the capacity-building concept into professional practice,

Capacity, most simply defined, is the ability to carry out stated objectives... In the context of PHN practice, it relates to the ability at various levels (individuals, groups, organisations, workforce, systems, state, ecosystem) to perform effectively,

efficiently and in a sustainable manner in order to achieve objectives such as improved health (Baillie, Bjarnhalt, Gruber, & Hughes, 2009, p. 1032)

Capacity building that is, confidence and problem solving capabilities, has been identified by Smock (2004) as so relevant to effective PHN action that it “should be considered a central strategy in PHN practice, important in all stages” of programme development (Smock, 2004, p. 1031). The relevance of capacity building in communities was seen by Smith, Conveney, Carter, Jolley and Laris (2004) in a state nutrition intervention that aimed to increase the knowledge and awareness of healthy food choices and consumption of healthy food in children and young adults in South Australia. They concluded that a better appreciation for capacity building outcomes such as problem solving, partnership development and engaging of stakeholders, developed and demonstrated more effective programmes for tackling health problems than the current focus on the traditional understanding of success, such as short term or clinical outcomes (weight loss, reduction in blood pressure etc.). The CD model provides a clear strategy for nutrition practitioners to develop capacity and meet the gap in policy initiatives for tackling the wider forces affecting diet “on the ground”.

Taking an alternative approach, from the conventional that address health inequalities for the individual, by using a CD model to enable the capacity to address nutrition related health inequalities is supported (Baillie, Bjarnhalt, Gruber, & Hughes, 2009; Smock, 2004). As, despite policy efforts, health

inequalities are widening, and public health nutrition practitioners need to address the many conflicting and contending forces influencing our food choices (structural and physical) and “engage” people with their health so as to reduce the burden of ill health on NHS resources (Wanless, 2004). Evaluating the outcomes achieved from approaches that follow the CD model such as problem solving capabilities, empowerment, engagement and the increased capacity of individuals would also provide a measure of effectiveness that demonstrate the worth of community projects in addressing the known barriers to a healthy diet and fill the gap between policy and practice (Dowler & Caraher, 2003). The change in the evaluation of approaches would also require an examination of methods used to assess effectiveness, this is explored in chapter 2.7.

2.6.4 Agents of community change

The term “Community Health Worker” (CHW) came into use in the UK in the early 1980’s however, the concept dates back to the 1960’s (Frankel, 1992) where health promotion and primary care interventions use community members in a “frontline outreach capacity” (Love, Gardner, & Legion, 1997). They are individuals from a community that are recruited to deliver healthcare services within that community. The use of local people in this capacity in the UK came about due to the recognition that they have a better understanding of the difficulties faced by their peers, serving as “culture brokers” between the community and health care systems.

These community health workers (CHWs) are also known by various other names such as health promoters, health volunteers, family welfare educators, community health aides (Frankel, 1992), lay health workers and community outreach workers (Swider, 2002). Essentially CFWs fulfil a similar role to convey culturally appropriate intervention, defined as “any health worker carrying out functions relating to health care delivery; trained in some way in the context of the intervention and having no formal professional or paraprofessional certificate” (Lewin et al., 2005).

The community food worker is described by Kennedy (2006);

Their broad remit is to provide support, encouragement and guidance on food and health issues, health promotion and eating healthily. They receive training in basic aspects of healthy eating, group and community work. Once trained, they are employed, typically on a minimum wage, to support professionals and formal health services in their role to improve levels of healthy eating amongst socially disadvantaged or underserved communities. The basic rationale for LFHW [lay food and health worker] is premised on the belief that people indigenous to the communities they serve will share similar social and cultural values to members of the target audience, thus facilitating communication between the formal health services and the so-called 'hard to reach'. The increased accessibility and enhanced communication thereby achieved

mean that LFHW might serve as successful change agents in promoting healthy eating. (p. 21)

The use of local people in this capacity is in recognition of their ability to utilise natural empathy within their native community and their unique understanding of the particular difficulties and limitations experienced by residents. Consequently they serve as 'culture brokers', mediators between two cultural systems (Van Willigen, 1986) acting as the linking step between the community and health care systems or directly providing healthcare services themselves as peer educators. Therefore, they have a greater understanding of the difficulties and wider forces affecting health. Typically they are ethnically, experientially or socioeconomically indigenous to the community in which they operate and are seen as an invaluable and cost-effective way of providing culturally appropriate health advice to their peers (Love, Gardner, & Legion, 1997). For their ability to empathise with communities and act as an appropriate source of relevant information suggests that this type of approach could be effective in influencing health.

The National Occupational Standards for Community Development Work details the skills and practice principles required to engage in community development work. The principles hinge on effective working with individuals or groups for this process. Local leaders, community and informal groups are the "gatekeepers" that will enable the identification of need, appropriate representation (advocacy) and therefore the building of social networks and capacity for groups and individuals (PAULO, 2003). Therefore, effective

leadership is at the heart of the CD process. By allowing communities to enjoy greater participation in identifying their needs and in designing the solution to be implemented, the process instils in the community a degree of control, and in individuals a sense of empowerment, thus building capacity by increasing the problem-solving capabilities of individuals and organisations (Easterling, Gallagher, & Lodwick, 2003). An approach such as this is proposed to create self-sustaining united communities (Hawe, King, Noort, Gifford, & Lloyd, 1998).

In a review of lay health workers from studies around the world, Lewin et al., (2005) demonstrated positive results in a range of situations; promoting immunisation, breastfeeding, screening for breast cancer and, providing support for hypertensive patients and recovering alcoholics. They have been shown effective for improving access to health care in underserved populations and “hard-to-reach” groups including the homeless, unemployed, pregnant women and young mothers residing in hostels, and for initiating changes in nutritional knowledge and food and cooking behaviours (Boyd & Windsor, 2003; Buttriss et al., 2004b; Kennedy, Ubido, Elhassan, Price, & Stephoton, 1999; Swider, 2002). Likewise, the peer education approach has also been shown to be successful within higher socioeconomic groups for improving general and sports nutrition knowledge in young female athletes (Kunkel, Bell, & Luccia, 2001). However, significant conclusions have still to be made on their use and effectiveness, and a distinct role definition is still required in order to give them a defined place in the structure of a modern

healthcare setting and for there to be any meaningful evaluation (Kennedy, Milton, & Bundred, 2008).

Support for the use of community workers is seen in *Choosing Health* (DoH, 2004) with the proposed development and implementation of the Health Trainer. The white paper identifies one of its key objectives as improving local diets using community food projects via the education and training of members of the community, in order to motivate others to change unhealthy lifestyle habits. However, their use has been criticised for the lack of evidence on effectiveness and a lack of coherence with the social models of promoting health that is CD (Kennedy, Milton, & Bundred, 2008).

It would appear that, the effectiveness and value of the CFW, if implemented under an informed health promotion strategy such as CD, could be further explored when measured against CD outcomes. An examination of CFW would provide valuable evidence on the effectiveness of the approach when interrogated under CD theory and further add to the evidence base on their use in policy and practice.

2.7 Evaluating community interventions

Investments in community food interventions need to be justified. The summation of the evidence presented suggests that community food projects are valuable for addressing the many barriers to a healthy diet, however the evidence presented in their support is varied and inconclusive. This research

has so far suggested a new model for implementing dietary change strategies therefore an alternative approach is needed to evaluate the associated outcomes. For this reason, the approaches taken to evaluate these projects and the outcomes used to measure them are under examination.

The following section provides an overview of evaluation research, the steps taken to evaluation planning and the current approaches to evaluate community interventions. It describes the current thinking on evaluation and explores the need for robust methodologies, and then addresses some of the key limitations surrounding evaluation and aims to set out the argument for new and meaningful evaluation approaches in PHN.

2.7.1 The why, how, what, where, when and who of evaluation

Øvretveit (1998) defines evaluation as:

attributing value to an intervention by gathering reliable and valid information about it in a systematic way, and by making comparisons, for the purpose of making informed decisions or understanding causal mechanisms or general principles (Øvretveit, 1998, p. 9).

As Øvretveit (1998) explains, the specific purpose of evaluation, as a research technique, is the gathering of data specifically for the purpose of discovering “causal mechanisms” that judge the value or merits of an initiative, that it is an investigation for an intended, practical purpose. Put simply, the object of

evaluating a community initiative is to provide information on whether a programme has been successful in achieving its aims and if not, why not. The quote below exemplifies the importance of evaluation;

When compared with the creative and exciting process of conceiving and initiating a project, evaluation can often be forgotten and be perceived as dull! However, some form of evaluation or formative feedback is the only thing that will show the effectiveness of the project (SHEU, 2006).

There are a number of reasons why there is a need for evaluation in community based initiatives; to provide evidence of effectiveness based on pre-defined aims (impact evaluation), to inform the intervention process (formative evaluation) and, for cost efficiency or quality of service (efficiency evaluation) (Fink, 2005), these are summarised in Box 2.4 below. Due to the need in healthcare to demonstrate effectiveness and value for money it has been argued that evaluation is the most important feature when designing interventions (Tones & Green, 2004).

Evaluation findings are needed to contribute to the research base on community interventions and more importantly, have the potential to influence local and national policy development (Garcia, Vargas, Iam, Smith, & Parrett, 2013). With this in mind, these questions have to be asked:

- Who or what is the evaluation for?

- Are evaluations using meaningful approaches to assess effectiveness?
i.e. the use of methods that tell us more versus the information that funders want to know
- Can the evaluation be made more meaningful?

Box 2.4 Summary of objectives in evaluation

- To inform the project – assessing/appraising project activities to varying degrees to be fed-back into the planning process of the programme
- For cost effectiveness – in a situation where resources are limited, funding allocation depends on demonstrable effectiveness.
- For stakeholder satisfaction e.g. funders, beneficiaries, partner organisations, staff and management
- To assess the impact – e.g. on individual or public health
- To contribute to existing knowledge – to prevent the repetition of work already carried out and to identifying effective health promotion practice which others can adopt.
- To influence policy development

The how, what and who of evaluation

The definition of outcome here is “the effect produced”. Outcome or impact evaluation describes the impact of an intervention when compared with programme goals (Gibney, Margettes, Kearney, & Arab, 2004). Outcome evaluation happens at the end-stages (and possible further) of an activity or

project. Evaluations will be concerned with either of these or, where it is important to know the effect and the process by which it was achieved both process and outcome evaluation will be used.

Robust methodologies are needed to demonstrate project specific causality (Lewin et al., 2005; MRC, 2000). Randomised controlled trials (RCTs) are considered the gold standard in health research particularly for the low risk of introducing bias and their overall accuracy. Their particular purpose however, is the evaluation of a single variable e.g. vaccination or treatment procedure (Crombie, 1996). Such is the complex nature of health promotion initiatives evaluation can often become very confusing. For example, interventions often involve more than one outcome, many kinds of activities, different time scales and a number of partner organisations (Lazenbatt, 2002). Community food interventions aim to tackle a range of barriers to healthy eating by improving nutritional knowledge, cooking skills and access to healthy food by developing fruit and vegetable schemes or community gardens. Therefore, there is no single altered variable to be investigated and no single outcome to be measured, making it very complex to use a quantitative research design.

Quantitative methods are often used within an experimental design and include randomised control trials, and cross-sectional surveys (Anderson et al., 1998; Beresford, Curry, & Kristal, 1997; Lin, Chen, & Chou, 1997). The Medical Research Council (MRC, 2000) proposed a framework for the use of the randomised controlled trial (RCT) for the evaluation of complex health interventions and for evaluating complex interdisciplinary interventions with

multiple dimensions and outcomes. The MRC described a complex intervention as something that has many independent and inter-dependent variables, the example given is of a stroke unit. The framework that was put forward by the MRC is based on the phases taken by a clinical drugs trial, the phases include a pre-clinical theoretic phase followed by the modelling of mechanisms, an exploratory trial, a main trial and a surveillance phase. The framework given would have resonance for interventions where variables and outcomes were clearly defined however, where interventions are more complex than the examples given, further thought will have to be put into the design of evaluation by practitioners/researchers. They will have to consider the influences and circumstances surrounding the intervention e.g. the “background noise” social influences and other inter-linking community interventions creating biases.

Due to the range of activities deployed by complex community initiatives and limited resources it is often impossible to evaluate every component of the intervention. It is important to decide what is to be evaluated; this is often informed by the project aims and objectives (“what”), from whose perspective the evaluation will take (“who”) and then, what method(s) to use (“how”). The evaluation method(s) used will depend on the outcomes wishing to be explored, and this will be evident from the objectives set during the project planning process. For example, reduced mortality rates and incidence of disease rates are robust measures of effectiveness however, they are unrealistic measures of success when seeking knowledge, attitude or perhaps CD outcomes.

The where and when of evaluation

The intervention outcomes should be considered to address the question of “what is to be evaluated and when?” Process is the relationship between the intervention (for example, actions, resources and organisational structures) and the effect. Process evaluation is concerned with programme implementation and can provide information on how the evaluation is organised, delivered and received, it addresses participant perceptions and can identify any factors responsible for success or failure (Lazenbatt, 2002). Watt, McGlone, Russel, Tull and Dowler (2006) evaluates the process involved in the recruiting, training and supporting of volunteers to implement a social support infant feeding programme for new mothers. The authors use process evaluation to describe in detail the experiences and insights gained whilst implementing a new health promoting intervention, which provides valuable information on the implementation of a social support intervention. The CFW would appear to be pivotal for the development of CD outcomes here, as such an investigation of the nature of their role in the implementation of a community food intervention is timely.

It is important to time the evaluation to address the issues that are most important to the intervention or if possible to do so identify immediate, mid-term and long term outcomes for evaluation at different time periods (Naido & Wills, 2000). If an intervention was to take sustained behaviour change as the only outcome measure, the success of a programme will be missed if the

evaluation is carried out too early in the intervention. As explained already, community food interventions are limited by fixed term or inconsistent funding therefore, measuring the most appropriate outcomes that suggest sustainability of the approach would be favoured for the continued funding of operations.

2.7.2 Current approaches to evaluation

A positivistic approach and therefore, quantitative methodology has always been favoured in the healthcare setting for demonstrating causal mechanisms. Scientific evaluation of medical interventions harks back to the “new” public health of the 1970’s and 80’s (Baggott, 2000). Although this is justifiable on an individual basis, and for whole population health assessment, it is less effective for enabling the understanding of Public Health approaches and the appropriateness of public health policy (Hubley & Copeman, 2008; McKinlay, 1993).

There has been some assessment of the reliability and validity of the use of certain quantitative questionnaires in the evaluation of a community based nutrition intervention in the UK (Anderson, Bell, Adamson, & Moynihan, 2002). To assess the impact of an after school cookery club on knowledge of nutrition, knowledge of food preparation skills and confidence to cook, Anderson, Bell, Adamson and Moynihan (2002), after a substantial development stage, designed an evaluation tool in the form of a questionnaire

to assess these particular outcomes. They found that the intervention was successful in developing nutritional knowledge but less so for increasing knowledge of food preparation and cooking confidence (no p values given). The authors recognised that community food based interventions were providing positive health outcomes. However, due to the multifactoral influences on nutritional behaviour such evaluations are “problematic”. Limitations of the questionnaire and questionnaire design were acknowledged, in that the questionnaire would not be suitable for all ages (this study was aimed at ages 10-13yrs), socio-economic backgrounds or populations. Also, the nature of questionnaires may have added bias to the research by influencing nutrition behaviour further.

The research by Anderson, Bell, Adamson and Moynihan (2002) demonstrated that alternative methods of evaluation would be more suitable to measure the interventions' impact. The authors acknowledged that the tool was not designed for use in a practical intervention and as such, there is a danger that the effect of the intervention, in terms of practical exercise with peers, may go underestimated. This example in the research and another from a Scottish community food initiative by Garcia, Vargas, Iam, Smith and Parrett (2013) shows questionnaires are limited. Questionnaires, for the purpose of evaluation, will always be limited by the questions they ask, namely those associated with intervention aims. However, does this mean that possible other outcomes including unintentional outcomes, go unmeasured? For example, CD outcomes such as confidence, capacity and building cohesive communities (Garcia, Vargas, Iam, Smith, & Parrett, 2013)

Ashfield-Watt, Welch, Godward and Bingham (2007) carried out an evaluation of a pilot nutrition intervention aimed at increasing awareness, access and attitudes towards fruit and vegetables in deprived communities. Intervention effectiveness was measured using the five-a-day community evaluation tool (FACET), a tool designed by the authors to assess diet and attitudes towards fruit and vegetables. The questionnaire was able to determine that intervention subjects were generally more aware of the five-a-day fruit and vegetable requirement and that access to fruit and vegetables increased ($p < 0.001$). The research saw a trend towards increased consumption with increased access and awareness however, the intervention was unable to alter fruit and vegetable intakes and actually experienced a significant reduction in vegetable intakes ($p < 0.01$). Although the tool was found to be suitable “in the field”, its validity and reliability are questionable that is, response bias, approval bias and sensitivity. A control group was used to increase validity, however it was not well matched for age, smoking and residential area. The authors recognise the need for further study on the mechanisms on food choice and why a perceived increase in awareness and access did not lead to behaviour change. What is apparent from this research is that the evaluation was limited in terms of the estimation of impact, and explanation of effectiveness, suggesting the need for more explanatory methodological approaches.

Silver, Ireys, Bouman and Stein (1997) used a randomised controlled pre and post-test design to evaluate the effects of a community-based support

programme for mothers of children with on-going health conditions. Their intervention aimed to provide support and access to services for improvements in maternal mental health using a peer-counsellor approach. The study experimental group (n=33) participated in six face-to-face or telephone interviews wherein a twenty-nine item psychiatric symptom index (measures variables including anxiety, depression and anger) and a forty-six item life stress event form were completed (amongst other measures).

The evaluation by Silver, Ireys, Bouman and Stein (1997) was unable to show any significant difference in psychiatric symptom index scores between groups. However, adjusted scores were directionally lower in the experimental group indicating improved mental health. This research focused on the mediating variables and whether the intervention was more successful for particular participants. Analysis was unable to show any particular difference between socio-economic statuses, demographics, or for level of involvement in the programme. The evaluation approach taken was unable to show any significant outcomes as a result of the intervention, the authors also acknowledge that they were unable to determine the usefulness of the approach, that being the use of a peer-counsellor.

Anecdotal and qualitative feedback gathered after the interviews did however provide an insight into some other effects of the intervention. For example, participants felt the programme provided an appropriate level of support and that the peer-counsellor was instrumental in providing a relationship that gave understanding, hope, an altered perspective and a sense of empowerment.

The intervention by Silver, Ireys, Bouman and Stein (1997) may not have provided the outcomes intended however, qualitative data indicated that the intervention was able to meet programme aims, and a mixed method approach using both quantitative methods as above and qualitative interviews may have provided the insight researchers were looking to explore. This detailed explanation of the research by Silver, Ireys, Bouman and Stein (1997) demonstrates the ability of qualitative methods to explore the unintended outcomes of an intervention and further explore the merits of their implementation.

Qualitative and dual method approaches

The number of outcome variables involved in community based initiatives (CBI's), e.g. nutritional awareness, cooking skills, cooking confidence etc., especially health care interventions, can make finding the "active ingredient" complex (MRC, 2000). An awareness of the mechanism or process for success allows effects to be replicated and interventions to be applied in alternative contexts. This requires researchers to use a number of evaluation methods in order to draw inferences on the possible process by which effectiveness has been achieved and implications in terms of wider implementation.

The Medical Research Council guidelines (see p. 79 above) (Campbell et al., 2000) received criticism from the research world due to a lack of evidence-base for their recommendations, and the lack of consideration for the social,

political and geographical context of these interventions (Campbell et al., 2007; Campbell, Donner, & Klar, 2007; Hardeman et al., 2005; Oakley et al., 2006). Consequently, they were revised to include observational and dual quantitative and qualitative approaches to evaluation (Craig et al., 2008, p. 6).

Bonner (2003) suggested that the desired medical model for evaluation leaves no scope for the mechanism by which the community intervention produces its effects or allows for the context in which these effects were produced. Qualitative approaches are used to record and understand process, people's experiences, attitudes and influences and barriers to behaviour. Qualitative methods have been used to assess indicators of community development such as levels of empowerment, confidence and self-efficacy (Germann & Wilson, 2004; Smith et al., 2004)

The breadth of outcomes to be evaluated by projects has led to the use of a multi-method approaches, which recognise the need to use a combination of qualitative and quantitative methods (Wreiden et al., 2007). Examples of qualitative techniques are, case studies, ethnography, focus groups and interviews. The merits of qualitative methods are the ability to record and understand people's experiences, attitudes and behaviour. As the quote from Pope and Mays (1995) explains, qualitative methods explore the hypothesis, rather than answer it. Qualitative studies are concerned with answering questions such as "What is X and how does X vary in different circumstances, and why?" rather than "How many Xs are there?" (Pope & Mays, 1995, p. 43)

Allender, Cowburn and Foster (2006) reviewed a number of qualitative studies designed to improve understanding of the barriers and enablers to participation in physical activity (PA) interventions, either in the community, through schools or as part of GP referral schemes in the UK. Although the research in the area was said to be small and limited in terms of theory base, it was found that qualitative methods were best placed to explore and understand the “how, why and when” in terms of adoption and maintenance of change in PA behaviours. The main factors that enabled participation of PA for all age groups were found to be increased social interaction, skill development, fun and enjoyment. Overall, the barriers to PA were stated as cost, time, low self-esteem and confidence and, a negative self-image. In particular, it was concluded that women of low socio-economic status were most likely to avoid taking part due to stigmatism from others, and that men of the south Asian or black community saw PA as not relevant to themselves. This research example advocated the use of peer-educator role models to improve involvement for these population groups, and qualitative methods were used to demonstrate their value.

Matthews, Berrios, Darnell and Calhoun (2006) used focus groups to evaluate the effectiveness of a faith-based breast cancer and cervical cancer screening programme for increasing knowledge of the risk factors and screening guidelines and, intentions to adhere to cancer early detection screening recommendations in America. The evaluation had a quantitative component and a secondary qualitative component that looked to support and add detail to the quantitative data. The qualitative evaluation aimed to explore a number

of variables including participants' attitudes regarding the role of the church in promoting health and the facilitators and barriers to adhering to cancer screening recommendations. The evaluation had a formative capacity, and also asked for recommendations for improvement so as to feedback into the programme.

This was a complex intervention involving “standard” interventions at all sites (n=9), delivered by the intervention team and “variable” interventions. Members of the congregations, trained as peer-educators, delivered variable interventions, these activities were unique for each church. With the use of focus groups, the investigators (Matthews, Berrios, Darnell, & Calhoun, 2006) were able to demonstrate the effectiveness of this type of intervention for increasing awareness of breast and cervical cancer screening programmes and for improving knowledge of factors associated with breast and cervical cancer.

The study by Matthews, Berrios, Darnell and Calhoun (2006) advocated the use of peer-educators, empowered members indigenous to the congregation/community, for facilitating action towards screening. This approach was able to determine the barriers and facilitators to screening behaviour, for example, more expected outcomes as a fear of the cancer, forgetfulness, negative experiences, low awareness, and unexpected outcomes as social stigma attached to cervical screening and to the results of the screening. It showed qualitative methods as ideal for providing explanations that can inform and establish programme design that targets

specific community groups. However, due to the nature of qualitative methods, further research is needed with regard to the generalisability of this type of intervention, and to the evaluation of quantitative outcomes.

Wreiden et al. (2007) used a dual approach to evaluate the impact of a community-based food skills intervention in a high deprivation area of Scotland. The authors used a complex evaluation methodology consisting of multiple methods (diet diary, food frequency questionnaire, shopping diary, observations etc.) to assess impact in terms of cooking skills, dietary behaviour and cooking confidence. Despite the rigorous approach, the evaluation was unable to demonstrate significant sustained changes on the part of participants towards healthier dietary habits or food preparation habits. However, a significant change was observed in cooking confidence, particularly in how to follow a recipe ($p < 0.05$). Participants also reported an increase in their ability to prepare meals from basic ingredients and to cook certain staple dishes (e.g. lentil soup and white sauce). This was supported by qualitative approaches that also saw an increase in enthusiasm to cook. The evaluation results were limited by low recruitment, due to lack of community resources, and high attrition rates due to the considerable and sustained involvement of participants over a six-month period. The outcomes of this research are valuable, as they have shown the limitations of evaluation approaches in the community. Although there is a call for the use of gold standard evaluation methods, this places a burden on participants and researchers that is unrealistic “on the ground”. This burden results in a

compromise between what is capable and what is required which ultimately yields inconsistent results.

Kennedy et al. (1999) incorporated both process and outcome aspects in her evaluation of the Bolton Community Nutrition Assistants (CNAs) project, where the aim was to promote healthier nutrition using a community development approach. The aims of the evaluation coincided with the aims of the project. These were, to examine the efficiency and cost-effectiveness of community nutrition assistants and community dieticians, explore the feasibility of establishing a network of CNAs and identify any cost savings. Kennedy et al. (1999) used qualitative methods to address the research aims.

Ellis and Hogard (2006) described a three pronged approach, evaluation of outcomes, process and multiple stakeholder perspectives in response to clinical, social and environmental interventions. Evaluation is most often carried out for key funders, who tend to insist on evaluation by an independent body to assess effectiveness of the scheme and perhaps more importantly for them, value for money. For evaluation of stakeholders, the key “players” in the scheme need to be identified, for example, users, implementers, initiators, funders and outside organisations. Evaluation of stakeholder perspectives is likely to be carried out using qualitative interviews, focus groups and observations (Ellis & Hogard, 2006).

Evaluation of a community cook scheme in Knowsley, Liverpool used a multi-method approach that incorporated structured questionnaires, interviews,

focus groups and observations with adult participants and trainers (community cooks). This enabled examination of a range of activities undertaken in relation to project objectives to assess impact, at both an awareness raising and behavioural change level (Ellahi & Gregg, 2006). Analysis of the findings showed, change or intention to change, in terms of improving the healthiness of the diet and specifically for salt intake and fruit and vegetable intake. Findings demonstrated the importance of the peer educator role of the community cooks in addressing common barriers to change such as cooking skills, access and confidence in addition to knowledge of a healthy diet. Through triangulation of the data, qualitative outcomes supported these findings (Ellahi & Gregg, 2006). What was apparent from the research presented here are the merits of using a mixed approach of qualitative and quantitative methods of data collection to produce a thick description of dietary behaviour. Carman (2007) found that where anomalies appeared in the questionnaire results, an explanation could be found from the interview analysis that is, triangulation of findings.

Thus, a combination of qualitative and quantitative methods are more readily used to meet community-based programme evaluation needs (Garcia, Vargas, Iam, Smith, & Parrett, 2013; Blom-Hoffman, Kelleher, Power, & Leff, 2003; Caraher & Cowburn, 2004; Carman, 2007; Kennedy & Ubido, 1998; Kennedy, Ubido, Elhassan, Price, & Stephoton, 1999; Rankin, Truman, Backett-Milburn, Platt, & Petticrew, 2006; Smith, Conveney, Carter, Jolley, & Laris, 2004; Wrieden et al., 2003). On the subject of methodological appropriateness in evaluation, Mckinlay (1993) comments;

The utility of any methodological approach is, in large part, a function of the load you're asking it to carry: and who it's being delivered to. (p. 115)

2.7.3 Limitations of current evaluation approaches

Carman (2007) looked at current evaluation practice amongst non-profit community based organisations in the USA. The author reviews the evaluation practices that have been conducted, the types of information collected, the methods of data collection, the person responsible for conducting evaluation and the funding available for evaluation. Through the use of qualitative interviews and the subsequent development of a mail survey, this research found that there was very little distinction made by community based organisations between audit practices (monitoring data, financial audit, management practices and staff performance review) and the evaluation of outcomes. There was particular confusion found between the meaning of the terms input, output and outcome. The author states;

What we are seeing is that community based organisations are engaging all kinds of strategies in an effort to try to show that they are doing good work - producing reports, hosting site visits from funders, making sure they are providing the proper documentation in case files, establishing performance targets and monitoring progress towards goals - at the expense of the

one strategy that would actually help organisations know that they are doing good work – evaluation. (Carman, 2007, p. 72)

The review by Carman (2007) found that data tended to be collected in written form usually activity logs, working hours, pre/post testing and meeting minutes (outputs). Less than half of the community based organisations questioned gathered data using surveys ($p < 0.001$), focus group or telephone interviews. Evaluations were mostly internally conducted, only one out of the one hundred and seventy eight respondents used an external source for evaluation. Furthermore, funding for evaluation was stated as a percentage of the overall budget (6-10%) however, one in four social services programmes had no costs allocated for evaluation. The responsibility for conducting the evaluation came under the roll of executive management or management staff in addition to the responsibilities already in place for this position. This research shows a distinct lack of understanding of evaluation or lack of capacity to carry out effective evaluations. The author recommended a change to the emphasis placed on monitoring and audit type data from funding bodies, the support for all community based organisations from an external evaluator to improve internal evaluation capacity and, a move to the gathering of data on outcomes, not only for the purpose of funders, but to inform programme development. Although this research is American-based, the findings have resonance with the UK research reviewed in this section. Concluding that appropriate design and rigorous procedure that is, understanding towards evaluation and the capacity to carry it out, are key to effective evaluation.

Allison and Rootman (1996) discussed scientific rigour in research into health promotion interventions. The authors state that scientific rigour is important to disprove a “naïve evangelistic” view of health promotion interventions. The authors state that rigorous research is theory based and has sound design and, that all decisions made by the researcher could be influenced by their experience, training and background. The use of community participation in research may overcome these biases that is, the identification of own problem for research, leading to community empowerment and skills development. This is more conducive with the ethos of CD, that is, to enable people to increase control over, and improve their health. The use of qualitative and quantitative methods allows more scope for the investigation of variables in the community. Allison and Rootman (1996) also suggests, the researcher should be used as an “instrument” and therefore, is a part of the CD process.

Conclusion

The review of community based initiatives provided here shows three key similarities; firstly, dietary change as the intended outcome, Secondly, to fully engage people with their health and finally, enabling them to choose health as a key concept. When considering the evaluation of these projects, this thesis argues that interventions should take into account how individuals in a community live their lives in relation to making food choices, and how the community in which they live shapes these. This would enable a critical

examination of community-based delivery of health and in particular, the approach used in development and delivery of policy initiatives.

The present research calls for further development in the research of community based initiatives and supports a need for alternative approaches in evaluation that will emphasise the impact of community food initiatives (CFI's). In the research project discussed in this thesis, the community development theory has been used to underpin evaluation and as a methodological approach for measuring outcomes that demonstrate effectiveness in a way that has evidence-based impact. Here, evaluation is not based on the (supposedly) most robust method of evaluation, but the most appropriate that will link context, process with outcome, thus informing social change mechanisms on what works for whom and in what circumstances.

Limitations of the randomised control trial (RCT) design are known, as explained above, in that they require a large investment of time and resources, most often not available to community food initiatives (Linden, 2006). Access may be limited in RCT to population groups not involved in the scheme and, there are difficulties obtaining a significant sample size, isolating the variables wishing to be explored and susceptibility to bias (Greenhalgh, 2001). The use of a comparative study would answer the questions of why the intervention was successful, and identify what the MRC (2000) refer to as the "active ingredients".

Through evaluation of the process, outcomes and multiple stakeholder perspectives of a community food intervention, this thesis aims to answer the question of whether evaluation can be made more meaningful for practitioners and policy makers, with particular attention to the measure used and the aims against which evaluation is carried out.

Chapter Three:

Methodology of the Skelmersdale Study

3.0 Introduction

The previous chapter explained the inadequacies of existing methodological approaches to demonstrate the effectiveness of community projects. In particular, it revealed gaps in knowledge of basic methodological approaches for evaluation and thus the appropriateness of existing processes. In this chapter, an alternative way of thinking is applied to understand effectiveness in community interventions; a methodological approach that has not previously been used in PHN, which is designed to draw out the value of interventions and, better inform any future activity.

The central argument underpinning the adoption of a novel and qualitative approach is that it allows incorporation of the perspectives and realities of participants. Further, it allows incorporation of any unintended consequences of participation in a community food initiative in overcoming the everyday physical and social barriers to health.

In his classic work, Geertz (1973) gives us the image of “thick” description, that is, where behaviour is not just described but is also contextualised, in order to make it more meaningful to third parties. In relation to the understanding of food choice and eating, this implies that the research need is

to engage with subjects and to utilise research methods that enable readers (outsiders) to understand the richness of the lived experience (Lupton, 1995).

This chapter explains the theoretical basis of the research, outlines the research procedure and analysis techniques and details the ethical considerations. It shows how methods drawn from this anthropological perspective enable a better understanding of the impact of interventions and the experience of participants. Finally, it provides a discussion of study limitations.

3.1 Methodology

Crotty (1998) states that “meanings are constructed by human beings as they engage with the world...Before there were consciousnesses on earth capable of interpreting the world, the world had no meaning at all” (p. 43). We assign meaning to, and interact with our surrounding environment and this is different for every one of us. This is especially the case with the decisions we make around food (Germov & Williams, 2004).

Consequently, searching for objective, unbiased accounts of causal mechanism in food choice would be inappropriate. It is becoming more popular for professionals engaged in healthcare research to be informed by a socio-constructionist perspective (Crotty, 1998; Green & Thorogood, 2004). Constructionism argues against fixed meanings of events but that meaning

and interpretation are constructed through many social and individual forces (Berger & Luckmann, 1966).

Food choices are imbued with meaning, more so than is limited to its micro and macro-nutrient content (Watson & Caldwell, 2005). Food choices are a construction of many structural forces; our cultural background, social status, religious teachings, social interactions, gender roles, habitual/historical actions, economics, geographical situation, education and so on. Although, previously investigated by many, the mechanism by which we “choose” food is neither direct nor fully understood (Beardsworth & Keil, 1997; Fieldhouse, 1996; Germov & Williams, 2004).

To understand the reasons why people act as they do, it is central to understand what the world is like for them (structure) and their capacity to exercise choice independently to this (agency). That is, the constraints and opportunities afforded to them by self and situation (Germov & Williams, 2004). For those making choices concerning food, it is the relationship between structure and agency in their collective experience that needs to be kept at the centre of any study of interventions and their evaluation.

Earlier reports from the WHO (1978, 1986) have referred to the importance of the structural influence and the importance of capacity and empowerment in the process of change through the creation of supportive environments, strengthening community action and developing personal skills. So much were social forces considered at the centre of human health that these were

incorporated into the WHO definition of health, as “a state of complete physical, psychological and social well-being, not simply the absence of disease or infirmity” (WHO, 1946).

Examining how food choice might be socially constructed enables us to locate the actors, agents or “active ingredients” and, in this research setting provides the opportunity to gain a deeper understanding of the lived experience surrounding food choice for mothers of young children in Skelmersdale. In order to do so, this will require innovation in research methodology that acknowledges the complex nature of food choices decisions (discussion in the previous chapter).

3.1.1 Ethnomethodology

The tradition of phenomenology is ordinarily used in social scientific studies of the lived experience. These range from religion (conceptualised and developed through the work of Chantepie de la Saussaye) to, more pertinently for this study, eating (Ludwig, Cox, & Ellahi, 2011). Phenomenology is concerned with how individuals make sense of the world around them (their life-world) (Bryman, 2001). Employing a broadly phenomenological approach, the emphasis in this research is not placed on generalisability of outcomes but the variety and complexity involved in the choices of the participants.

Ethnography is a specific research tradition within phenomenology (Crotty, 1998). Ethnomethodology describes the methods used to look further into

what people say and what people do, beyond simple description or as a means to an end, where superficiality is rejected (Draper, 2004). Methods tend to be either interview or observation in various degrees from structured to unstructured, overt to covert (Draper, 2004). Not only is ethnomethodology a set of research methods, it also refers to representing the perspective of the participant accurately that is, gaining an insider's viewpoint and conveying a sense of "being there" through the findings (Mays & Pope, 1995; Savage, 2006). One of the more recent tools is that of ethnographic fiction as a means of communicating findings (Watson, 2000).

3.1.2 Ethnographic fiction

Discourse creates the world through language. As Burr (2003) explains, "[discourse] refers to a particular picture that is painted of an event...a particular way of presenting it in a certain light" (p. 64). Discourse and discourses (spoken, written word or representations) construct "the phenomena of our world", and provide our version of events which are constructions of our social life (Burr, 2003). Therefore, without some form of communication, the reality that someone experiences in their world does not exist externally to them.

Ethnographic study obtains information rich in both complexity and depth. Further, its engagement in the lived experience of the participant raises issues of confidentiality and anonymity in the report findings. Consequently, the field has a tradition of exploring novel means of communicating research findings

(Watson, 2003). An innovation in this field is the use of ethnographic fiction, which has arisen out of the need for less restrictive methods of conventional report writing found in ethnographic study. Instead, short fictional stories are produced that draw on actual data gathered in the field (Watson, 2003).

The researcher using ethnographic fiction (EF) systematically gathers a range of different types of empirical data. These multiple sources can be triangulated to add depth. Conventional analysis and reporting tend towards a reductive outcome in which the connected experience of the participant is reduced to fragmented data points. EF seeks to overcome this limitation by reconnecting this (systematically collected and analysed) data in the form of a fictional narrative (Spinney, 2007). Ethnographic fiction locates the person within the “place” to convey the significance of the “deeper social processes” at play as opposed to simple descriptions or the repetition of participant words (Watson, 2000).

It is important to acknowledge that interviewees are not always as articulate as one another, that it takes a number of experiences to draw all variables out, and presenting them together (as opposed to separate transcripts) provides a more accessible picture of significant outcomes. Consequently, this enables inclusion and mirrors the value driven and moral qualities found in community development theory (NOS CD, 2009).

EF has a number of particular strengths over conventional qualitative reporting methods. Firstly, it is not reductive but recombinant meaning that EF

allows the researcher to deal with vast, diverse and complex data (Watson, 2003). Secondly, it provides the freedom to move away from the “dry” representations, which is typical ethnographic report writing, to where speech is in context with setting and behaviour (Watson, 2003).

Watson (2003) summarises the process by which ethnographic fictions are formed:

It involves combining and reshaping the knowledge gained in several different research contexts into a meaningful and theory sensitive narrative. The ‘surface’ facts...locations and individual identities are changed but the ‘deeper’ social processes that have been observed are given direct attention. It is these underlying patterns, after all, with which, as social scientists, we are primarily concerned. (Watson, 2003, p.1308)

As a tool to communicate the intensity of the data, ethnographic fictions are developed in the present research out of discourse taken from observations, interviews, field notes and reflections collected on a number of occasions, which are then used to generate singular or multiple accounts (Sparkes, 2002). Where the ethnographic researcher is based in-situ, ethnographic fiction allows first-hand experiences to be conveyed.

3.1.3 Application of Ethnographic Fiction

Ethnographic fiction has not been used extensively in health research, nor has it generated an extensive body of research in this field (in comparison with more long established methods e.g. grounded theory (Glaser & Strauss, 1999). As illustration of the application of this method, Spinney (2007) uses it to relate the embodied experiences of 20 cyclists in London, to express their sensory-experiences of cycling, experiences that are said to be quite difficult to verbalise. Fictional events are created to convey a cycling route taking the reader through a variety of cycling (transient) spaces through London exploring the concept that mobility routes are not just a line between A and B. The fictions are used to retain “character and atmosphere” and to convey a notion of “being there” that could be “lost in translation” under conventional methods.

Sparkes (1997) originally used the technique within the sociology of sport in his study of gay, male sportsmen in America. Here, Sparkes (1997) used ethnographic fiction to present the lives of the unrepresented and to give voice to “silenced groups” that is, those who are oppressed due to their sexual identity in sport and other life situations. Parten-gerla (1995) uses ethnographic fiction to convey the complexity of life worlds and inequality in the events of two opposing lives. Through letters of correspondence, issues of education inequality, injustices and race are explored in 1950s America.

What these examples demonstrate are the varied uses of ethnographic fiction, that it has so many more applications than conventional ethnographic

reporting. Schmidt (1984) described it as a hidden literacy style “so useful in winning the general reader’s interest” and also for conveying truths about people’s lives through the written word.

The use of ethnographic fiction is controversial. Concerns have been raised on the balance between fact and fiction, that there is too much of the author in the representation and of the compromises made to produce a captivating story (Van Maanen, 1988). However, ethnographic fictions are used to represent the notion of the researcher being there in the field, having collected data in a variety of different ways (for example, multiple interviews of varying length and observations), these are then placed in a fictional story based on a setting that has been ethnographically studied. Researchers are witness to events, and thus hold a truth and authenticity that demonstrate the authors’ understanding of the situation (Sparkes, 2002). It is ground breaking in the field of public health nutrition, a field dominated by positivist scientific approaches, and as such will attract debate.

In his research on organisational strategy-making, Watson (2003) explains that as a method of reporting, the use of ethnographic fiction has a number of advantages over conventional report writing methods (see Box 3.1).

In the context of PHN, ethnographic fiction is a particularly useful tool. Not only can it convey new insights on food choice or shift the focus of thinking, more importantly it locates the participant centrally in the investigation. It gives a voice to the expert (the participant), an aspect at the centre of any

community development process, a process that is never more so emphasised in PHN policy. It would not be possible to construct and convey the social influences and the emotions involved in food choices using other more conventional methods of data presentation, in this research it has a specific analytical and explanatory purpose (Coffey & Atkinson, 1996).

Ethnographic fiction is used specifically to convey the wider conflicting and contending forces affecting food choice, to provide collective voices showing the connectedness of influences, and to give the mechanism of food choice a complex interwoven explanation (Frank, 2000). The aim is also to provide an authentic and truthful representation of participant's lives that will hold resonance with similar population groups (Hecht, 2007). Ethnographic fiction allows findings to be placed next to theoretical perspectives taken from wider research not only to try to further understand these influences on health but to make them accessible and understandable to the practitioner (Sparkes, 2002). Although it has not previously been used in this field, it provides practitioners with a full sense of food choice influences and allows examination of the role of a community food intervention in addressing these influences.

Box 3.1 – Advantages of ethnographic fiction over other qualitative data approaches

- It enables a closer matching of theoretical concerns and empirical observations than might be the case if the researcher were limited to reporting 'what actually happened' in the circumstances of a single case study. If the researcher is free to draw upon observations from several studies – combining them in a fictionalised narrative – there is greater opportunity to deal with the range of theoretically relevant issues than would otherwise be possible.
- The richer ethnographic cases that are possible can be especially helpful in the learning and teaching aspect of academic work. Again, more issues can be covered than is possible with a single or conventional case. Also, the case can be made more appealing if the writer uses the full range of fiction writing skills (Rose, 1990) than might be achieved with the 'dry' presentation that is typical of conventional cases.
- The freedom to manipulate material enables the writer to concentrate and compress the research account to a greater extent than is possible with a conventional research report. This makes it more feasible than is normally the case to deal with ethnographic material in the relatively brief format (Watson, 2003, p.1309)

3.2 Methods

3.2.1 Details of the Skelmersdale study

The study aimed to examine the main influences on food choice contributing to health inequalities for mothers of young children. This was done through the examination of the impact a community food intervention on the wider social forces influencing food choice. In doing so this research aimed to inform the policy relating to diet inequalities, the practice of public health nutritionists “on the ground” and further open up the debate on the factors causing health inequalities and how to address them.

What follows are the relevant details from the study (location and background) that enabled the introduction of EF as a means to understand the “lifeworld” and the food choices of those involved.

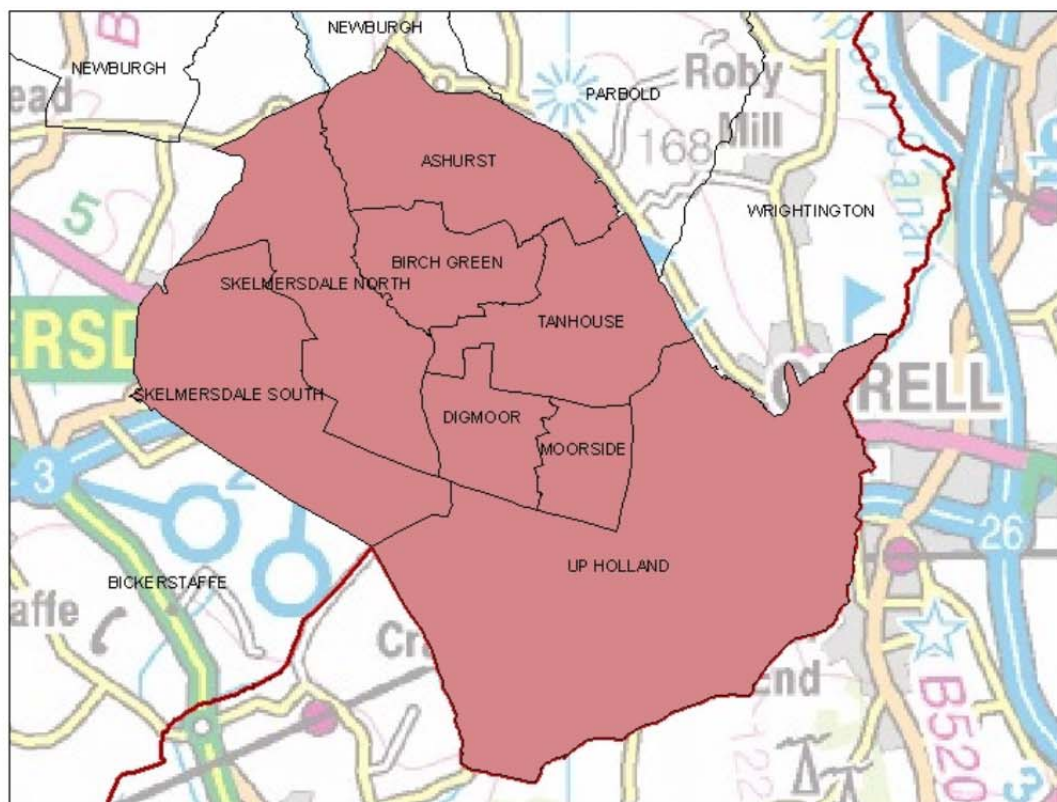
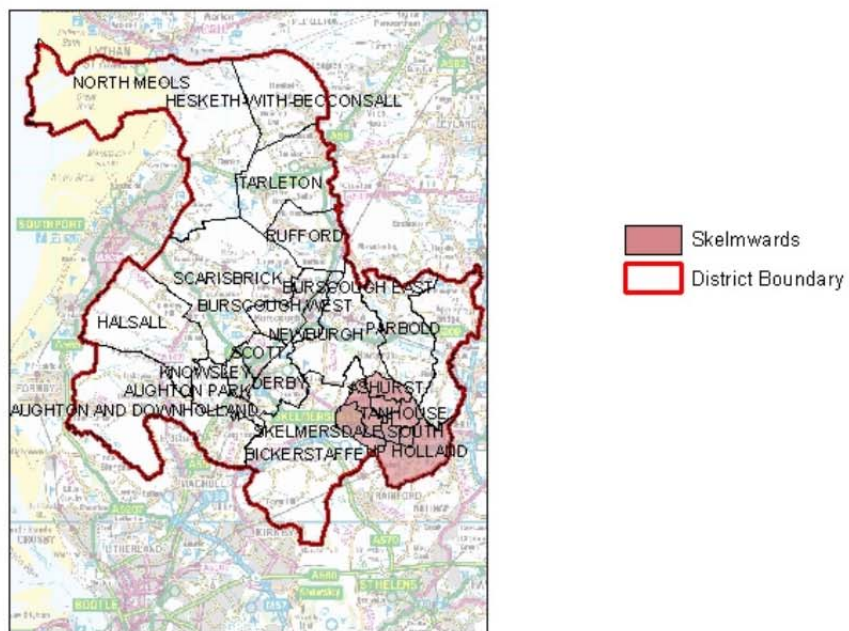
The research site

The community-based initiative that is the focus of this research is the Skelmersdale Community Food Initiative (SCFI; herein also referred to as the initiative, intervention or CBI). The researcher (RG) worked within the initiative as Evaluation Officer for project activities on a part-time basis from January 2006 – March 2008 (details of the project and Evaluation can be found in Appendix F-H).

Skelmersdale

This research was conducted in Skelmersdale, Lancashire, North-West England. Figure 3.1 displays the Location of Skelmersdale and its wards. Skelmersdale consists of 8 geographical wards; Ashurst, Birch Green, Digmoor, Mooorside, Skelmersdale North, Skelmersdale South, Tanhouse and Up Holland (Figure 3.1).

Skelmersdale was designated a “new town” development in 1961, it was built as an overspill to accommodate the populations of large deprived urban areas from north Merseyside and Liverpool in particular. Before redevelopment of the area, the region was best known for coal mining in the early 19th century however, Skelmersdale has suffered due to economic recessions of the 1980’s leaving the redevelopment unfinished and much of the population in deprivation. Consequently, there remains a legacy of problems relating to health status and health needs.



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Figure 3.1 The Location of Skelmersdale and its wards (West Lancashire Borough Council, n.d).

Skelmersdale is the most deprived area in the West Lancashire Borough with 14 of its 23 Lower Super Output Areas (60%) featuring in the top 20% most deprived nationally (LSOAs are areas smaller than wards consisting of between 1000 and 3000 people) (IMD, 2007). The wards of Birch Green, Digmoor, Moorside and Tanhouse all have LSOAs featuring in the top 1-20%. There are eight LSOA in West Lancashire ranked in the top 10% of the most deprived in England, all eight LSOA's are in Skelmersdale. This measure of deprivation is based on the 2007 indices of deprivation for England which is an accumulation of, The Index of Multiple Deprivation (IMD 2007), Income Deprivation Affecting Children Index 2007 (IDACI), Income Deprivation Affecting Older People Index 2007 (IDAOPI) and Local authority (and county council) summaries of the IMD 2007. The IMD 2007 measures deprivation relating to income, employment, health and disability, education, skills and training, barriers to housing and services, the living environment and crime. The most deprived LSOA's (relating to income, income deprivation affecting children, and income deprivation affecting older people) are placed within six wards across Skelmersdale, one in Ashurst, one in Birch Green, two in Digmoor, two in Moorside and two in Tanhouse. The LSOAs in Digmoor and Birch Green appear amongst the top 2% most deprived nationally (Figure 3.2 displays a ward map of the area with LSOA deprivation scores).

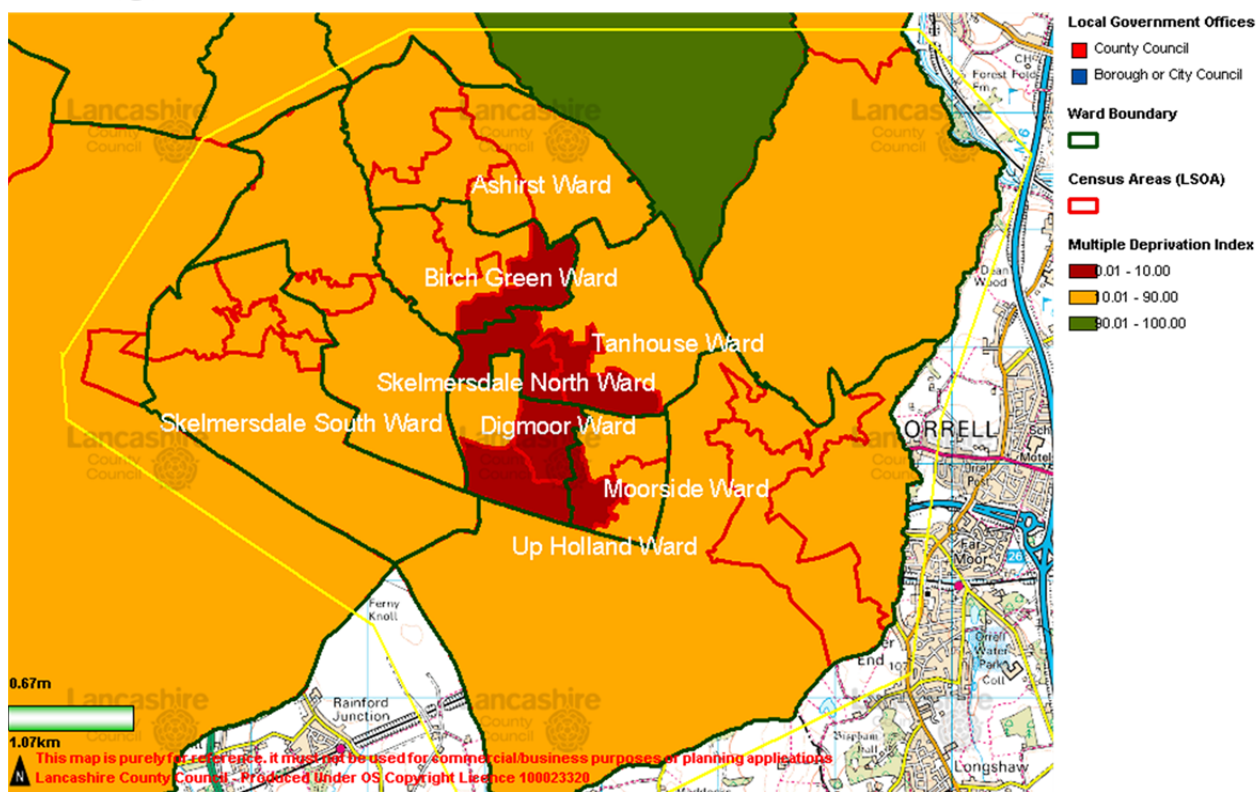


Figure 3.2 Ward map of Skelmersdale indicating LSOA deprivation

It is worth noting that within the same county of West Lancashire six LSOA's (Aughton and Downholland, Aughton Park, Knowlsey, Parbold and Tarleton) are ranked within the 10% least deprived nationally in terms of income deprivation and as such the LSOA is a way to identify extreme pockets of deprivation (Department of Communities and Neighbourhoods, 2008).

Rates of unemployment are highest in Skelmersdale with an average rate of 10.6% in 2001. Within West Lancashire, the greatest proportion of Job Seekers Allowance (JSA) claimants are found in Skelmersdale, particularly in the wards of that have high deprivation levels (Dignum, Birch Green and Tanhouse). Rates of JSA claimants in Skelmersdale wards are higher than

the Borough, regional and national rates (Department of Communities and Neighbourhoods, 2008).

15% of the Skelmersdale population claim Government benefits. This equates to 58% of West Lancashire's benefits claimants. Benefits include carers allowance, disability living allowance, incapacity benefit, income support/pension credit, job seekers allowance and severe disablement allowance (West Lancashire Borough Council. n.d). Those claiming benefits tend to reside in the most deprived areas of Skelmersdale, indicating significant unemployment and serious issues relating to low income. Of those in employment, more residents of Skelmersdale are employed in lower skilled occupations (36.8%) (West Lancashire Borough Council. n.d). These statistics reflect the high levels of skills, employment and income deprivation concentrated in this area. Skelmersdale's limited job opportunities, particularly skilled, technical and managerial jobs, generally provide lower wages and make social mobility increasingly difficult for many.

Ranked in the bottom 10% of deprivation in England Skelmersdale has widespread deprivation across the district and pockets of extreme deprivation. Figure 3.3 displays a map of the Skelmersdale area featuring population statistics. It is the largest and most populated area in West Lancashire. With a total population of 34,548 (32% of West Lancashire), it has a young, more varied population structure than other areas of the county (West Lancashire Borough Council, n.d.). Figure 3.3 shows that the Skelmersdale area (boundary indicated by the yellow line) has a greater population density

compared with other areas of West Lancashire. These areas of particularly densely populated within the most deprived wards in Skelmersdale; Digmoor, Tanhouse, Moorsey and Birch Green (indicated by the blue dots).

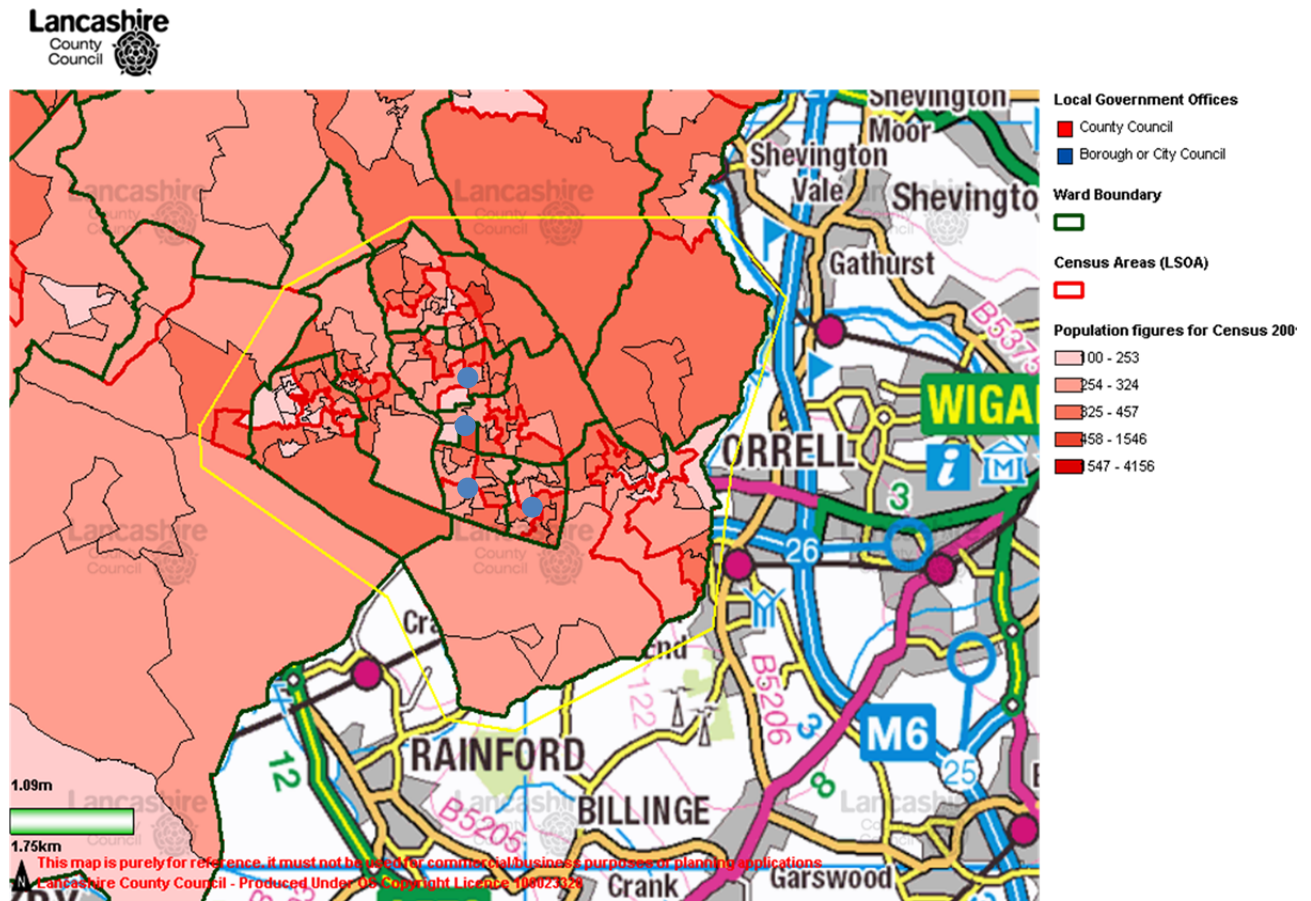


Figure 3.3 Population map of Skelmersdale

As a consequence of this relative deprivation, Skelmersdale has high levels of nutrition-related disease, in particular the risk of coronary heart disease and cancer have been well above national average and one of the highest in the North West (Flynn & Knight, 1998). Life expectancy within West Lancashire is poorest in the Skelmersdale wards of Digmoor, Birch Green and Tanhouse. People in the most deprived areas have life expectancies six year shorter

than those in the least deprived areas (West Lancashire Borough Council. n.d). The percentage of obese adults and infant deaths are close to the England average, but the deaths from circulatory disease are higher in the deprived areas around Skelmersdale, and are significantly above the North West average. The proportion of physically active children also performs significantly worse than the England average (Department of Communities and Neighbourhoods, 2008).

3.3 The research design

Semi-structured interviews and observation were the primary methods of data collection. Memos were also taken during and immediately after the interview to aid the reflection and analysis process. One to one semi-structured interviews were the chosen method of data collection as they are exploratory and able to provide detailed findings rich in breadth and depth (Bryman, 2001; Popay & Williams, 1996; Pope & Mays, 1995). Qualitative methods such as this are best placed to show alternative realities, to delve into the issues relating to food choice for mothers of young children, their experiences and influences of weaning and feeding young children and to explore the impact of a community intervention on this. Green and Thorogood (2004) comment;

The most basic way of characterising qualitative studies is that those aims are generally to seek answers to the questions about the “what”, the “how” or “why” of a phenomenon, rather than questions about the “how many” or “how much” (Green & Thorogood, 2004, p. 5).

3.3.1 Ethical considerations

An application was submitted to the School of Applied and Health Sciences (as was) Research Ethics Committee at the University of Chester and approval for this research was gained on the 27th March 2007 (SREC ref: 120/07/RG/BIOL). Informed consent procedures using a participant information sheet and procedures relating to data protection have been followed (Appendix A). A risk assessment for this research was undertaken for good practice using the University of Chester, Department of Biological Sciences risk assessment procedures.

Questioning participants on their lifestyle, behaviours, attitudes, shopping and cooking practices could possibly cause undue upset and distress. The research team (RG and supervisors) reviewed the data collection procedures to ensure that they would not induce any unnecessary upset and distress to participants.

Participants involved in this research were not exposed to any stress either psychologically or physiologically that is fatigue, stress or unpleasant side effects. Informed consent was requested from every organisation and participant taking part. The participant information sheet described the research, what happened to participants' details and the data collected and requests permission for the data to be used in this research (Appendix A). Participants were also asked to sign a consent form before proceeding with the research (Appendix A). The informed consent forms stated the purpose of

the study, the time commitment that participants had to make, how the information they provide was used and who has access to that information. The interviews did not take place before informed consent was obtained.

Participants were assured that all data would be kept in the strictest of confidence. Recordings and transcripts were kept on a password-protected computer where only the researcher had access to it. The participants were made aware that they were free to withdraw from the research project at any time and that they were also free to ask any questions on the research process.

3.4 Population and sampling

The population of interest were mothers of young children. They were chosen because of their point in the life stage, which places them at the centre of food choice decisions and their role in the development in the future adult's lifecourse (as discuss in section 2.1.2).

Included in the aims of this research was an exploration of the role and impact of a community intervention and the community development approach employed. This enabled the reflection of the broader socio-cultural experiences of food and the influence of "structure" and "agency" on food choices. This was also done in order to explore whether evaluation can be made more meaningful, and address questions with regard to their role, scope and impact. To do this a comparison was needed to be made between the

food choices made between those who attend a community initiative and those who did not. The term “client” is used to refer to research participants who attended sessions delivered by the staff running the CBI. The term “non-client” refers to research participants who have no links to the CBI.

This research is also interested in the wider social processes involved in food choice; social norms, social roles and social constraints. The terminology “client” indicates a certain amount of agency and empowerment and where as “non-client” is used to imply passivity and lack of engagement. As is pointed out by Burr (2003), the very act of attending a CBI indicates one’s agency, and it is this and the community development process that is of interest with regard to food choice.

The comparison of clients and non-clients was made in order to generate a total picture of food culture for all clients and to identify enablers to nutritional change as generated by the CBI. In addition, by investigating the factors relating to those that attend versus those that do not, the research is considering variables that could be there but are overlooked by other evaluation approaches. The use of a comparison group (non-clients) also allowed for nutritional change occurring not because of the CBI that is, accounting for any “background noise”.

Living in Skelmersdale was an inclusion criterion. Clients were included in the research if they had attended sessions delivered by the initiative and met the definition of, any mother of a young infant or child before they reach schooling

age (five years), as categorised by SureStart early years provision policies (DfCSF, 2003), and they provided informed consent. Non-clients were recruited if they also meet the definition as above, they agreed to the requirements of the research and they had no previous involvement with the CBI.

Clients and non-clients were purposely recruited. A purposive sampling strategy is described as a sampling technique that allows the inclusion of persons who would generate the appropriate data needed to address the research aims (Green & Thorogood, 2004; Mays & Pope, 1995; Pope & Mays, 1995). A “snowballing” technique was used to gain access to additional eligible participants, a technique used by both Beadsworth and Keil (1992) and Bryman (1995; in Bryman, 2001). Non-clients were identified from beneficiary data collected by the CBI. These groups were particularly targeted due to the clientele they serve within Skelmersdale. Partner organisations that were identified as eligible to take part in the research were contacted for their consent to participate, for example local community groups such as Children’s Centres, HomeStart centres or childrens’ play groups (in detail below).

3.5 Access and recruitment

Access to non-clients was negotiated through discussions with senior members of partner organisations (list in Appendix C). To encourage participation, the researcher entered into a dialogue with partner

organisations, they were given essential information regarding the researcher and the research. This allowed the opportunity for any concerns, enquiries or issues to be addressed, this was done via telephone, email or in person. The dual purpose of the research was explained to partner organisations in that, the researcher (RG) was Evaluation Officer for the community food initiative and a PhD student at the University of Chester.

At the time of sampling all five of the community organisations that were identified and approached gave their consent for their beneficiaries to be targeted by this research (see Appendix C for list of community organisations). Clients were approached to participate in the research by the researcher (RG), in person. RG gained access to clients through her role as evaluation officer for the CBI, and was given consent to do this by the management committee of the CBI. The recruitment procedure followed ethical guidelines in that participants were given information to consider and informed consent was gained prior to commencing data collection.

3.6 Data Collection

The semi-structured interview technique was chosen as the most appropriate method to elicit the required information and address the research questions. Interviews use conversation, based on specified “umbrella” topics, to generate data. The interview is the most widely applied technique to reveal the respondents’ understanding of the world and their experiences and

perceptions (Beardsworth & Keil, 1992; Denzin & Lincoln, 2005; Green & Thorogood, 2004; Lincoln & Guba, 1985; Silverman, 2004). Semi-structured interviews enable the research both to guide the interviewee towards key topics, and to allow for personal expression and the airing of individual agenda (essential for thick description). To prompt and guide the participant the semi-structured interview employed followed a flexible outline of themes explored via open-ended questions (in Appendix D). Alongside the more obvious recording of voices, ethnography pays attentions to setting and behaviours, as such interviews were accompanied by observation of the home environment (where possible) and the researcher (RG) took immediate reflections in the form of field notes. Triangulation of the data in this way allows the comparison between what people say and what they do, a key ethnographic technique (Jick, 1979).

3.6.1 Tool design and piloting

An interview guide was developed for the semi-structured interviews (see Appendix D). The guide was generated directly from the research questions under investigation, and the theoretical underpinnings of the research. The interview guide was designed so that particular topics could be discussed but that there was also opportunity for new and unexpected lines of enquiry to emerge, in this sense, it was both a deductive and inductive process. The interview guide was identical for both client and non-client groups except for an added line of inquiry for clients relating to participation in the intervention and intervention outcomes. The guide was used solely as a prompt for the

interviewer and in this way allowed the greatest level of flexibility during the interview. The topics under discussion are outlined in Box 3.3.

A further refinement was the use of a pile sorting exercise. This was used to enable the discussion with the less articulate participant and to open closed areas of discussion in the less reflective. It also allowed the researcher to explore the possibility of a hierarchy of influence on food choice that was emerging during early data collection. Previously, this technique was successfully used by Greenhalgh, Heman and Chowdhur (1998) to explore subjects' views on foods relating to diabetes. Here, the topics related directly to the interview guide and the responses gained from the pilot interviews. Participants were asked to discuss the influences on their food choices (if any) and to prioritise them from most to least influential. A photograph was taken of this pile sorting exercise to provide a record and to assist analysis at a later stage (Appendix E). The topics used in the pile sorting exercise can be seen in Box 3.2.

Box 3.2 Pile sorting exercise

Community group support	Being a parent
Family	Health visitor/Health professional
Self-esteem	My health
Children(s) likes/dislikes	Other nutritional advice
Quality of foods	Concourse
Access to shops	Involvement with Skelmersdale
Availability of foods	community food initiative
Cost	Skelmersdale community food
ASDA	initiative approach
Confidence to cook	Community food worker
Cooking skills	Skelmersdale community food
My food preferences	initiative information
My nutritional knowledge	Bag-a-bargain
Time to cook	Health messages e.g. 5 a day
Time of year	My cooking equipment
Skelmersdale area/my surroundings	Treats
	My job

Locations

The interviews took place in multiple sites over multiple interactions, either at participants homes, a community centre or office of the researcher (RG). The interviews were arranged at a time specified by the respondent in order to make them feel in control of the process (any safety issues and procedures were addressed in a risk assessment with the initiative). Due to the fact they had participated in a free community activity, clients were generally willing to participate in the research to give their feedback on the intervention and provide more detail on their food choices. Non-clients were given a voucher for the community initiatives fruit and vegetable scheme for a mixed bag of

fruit and vegetables in appreciation for their participation, to the value of £2.50 (Appendix I). These steps were taken in order to demonstrate reciprocity between the researcher and the researched (discussed further below).

Box 3.3 Interview topics for clients and non-clients

- Health behaviour: the importance of nutrition for health and other health behaviours
- Motherhood: any impetus to change dietary habits due to becoming/being a parent
- Structural influences: the Skelmersdale area, food access, food and eating processes, regular shopping behaviour, kitchen facilities, travelling arrangements
- Community development outcomes: confidence, self-esteem, health seeking behaviours and self-efficacy
- Affiliation and the influences of others: family circles, relationships and friendships, the role of agency
- Participation: participation in community or other activities
- Details of time, environment and people relations including some profiling data such as age, partnership status, employment, education, children and ages, family links and origins in the region

The semi-structured interview guide underwent piloting with the first five interviewees (four clients, one non-client). The tool did not need to be revised as it was eliciting the required responses.

3.7 Implementing data collection

Data collection began in May 2007 (excluding July and August 2007 where data collection was postponed for school holidays), and continued until saturation was achieved (approx. February 2008) (Lincoln & Guba, 1985).

The interviewer (RG) introduced herself at the start of the interview, then an explanation of the research and detail of the interview procedure that is, pile sorting was provided. As research “in the field” is an organic process, the researcher had to be responsive to the environment in which the interview was taking place, For example, the interviews varied in length typically lasting up to one hour, on occasion as little as twenty minutes and one interview up to three hours long. Generally, interviews were longer if they took place at participant homes or in a quiet office environment. Where interviews took place with children present or during a community sessions (e.g. play group), interviews were shorter but still generated valuable information on the food culture that was shaping the patterns surrounding food choice decisions.

The interviews were digitally recorded and descriptive notes were taken during the interview and for the pile sorting. Immediately after the interviews a reflective memo was recorded by the researcher to highlight any initial themes or observations.

3.8 Data sorting and analysis

Interviews were anonymised using a code, this referred to interviewee's first name initial, client or non-client status and number order. Interviews, including memos and observations, were then transcribed verbatim. The data was transcribed and analysed consecutively and used iteratively to feed into the research and inform the generation of theory (Lincoln & Guba, 1985).

As part of a two stage analysis process, the data was firstly fragmented using a thematic approach by computer package NVivo where particular themes relating to the research questions were looked for, and secondly the data underwent further investigation to reconstruct ethnographic fictional narratives, to present and understand specific life worlds (explained below).

3.8.1 Stage 1: Data sorting using NVivo

Thematic analysis took an inductive and deductive approach where expected and unexpected outcomes were found and coded, and thematic labels were applied to the data. The process is explained by Fereday and Muir-Cochrane (2006);

Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). The process involves the identification of themes through "careful reading and re-reading of the data" (Rice & Ezzy, 1999, p. 258). It is a form of pattern recognition within the data, where

emerging themes become the categories for analysis. (Fereday & Muir-Cochrane, 2006, p. 82)

This type of thematic qualitative data analysis has been described as a “black box that needs unpacking” referring to the mystery and the lack of rigour that surrounds it (Hoong-Sin, 2007, p. 111). There is therefore a need for analysis to become more transparent and systematic.

There are a number of ways an ethnographer can sort and classify qualitative data, before the generalised use of computers qualitative researchers copied, indexed and filed transcript data by hand (Dey, 1993). For this study, RG decided to employ NVivo. Computer assisted qualitative data analysis software (CAQDAS) is becoming ever more popular and has its strengths in allowing better handling and managing of vast quantities of diverse qualitative data (Dean & Sharp, 2006; Mangabeira, Lee, & Fielding, 2004; Wickham & Woods, 2005). More importantly, this is a relatively familiar method within the healthcare discipline.

The computer package NVivo 8 (QSR International, 2008) was used to sort the data line-by-line. Training was undertaken by the researcher (RG) prior to analysis. The procedure for sorting and coding the data followed the Thematic Network procedure described by Attride-Stirling (2001) (explained in Box 3.4 below). This approach was chosen as most appropriate for the complex subject matter at hand and due to its resonance with the interlinking pile sorting exercise used within the interviews. As web-like structures are the

outcome of thematic network analysis, this also influenced the decision to use the qualitative data analysis package NVivo to perform this stage of the analysis.

Box 3.4 Stage A of Thematic Network Analysis (Attride-Stirling, 2001, p. 391)

ANALYSIS STAGE A: REDUCTION OR BREAKDOWN OF TEXT

Step 1. Code Material

- (a) Devise a coding framework
- (b) Dissect text into text segments using the coding framework

Step 2. Identify Themes

- (a) Abstract themes from coded text segments
- (b) Refine themes

Step 3. Construct Thematic Networks

- (a) Arrange themes
- (b) Select Basic Themes
- (c) Rearrange into Organizing Themes
- (d) Deduce Global Theme(s)
- (e) Illustrate as thematic network(s)
- (f) Verify and refine the network(s)

Thematic network analysis followed the steps described in Box 3.4. Firstly, the data was coded, then organised and clustered into relevant themes. At this point, themes were arrived at deductively, firstly generating basic themes, which are then clustered into organising themes based on the pile sorting exercise. Then themes were organised into super-ordinate global themes

representing the over-arching topics within the interview guide. These were then illustrated as thematic networks (Figure 3.4) which were used to “verify and refine” the network structures.

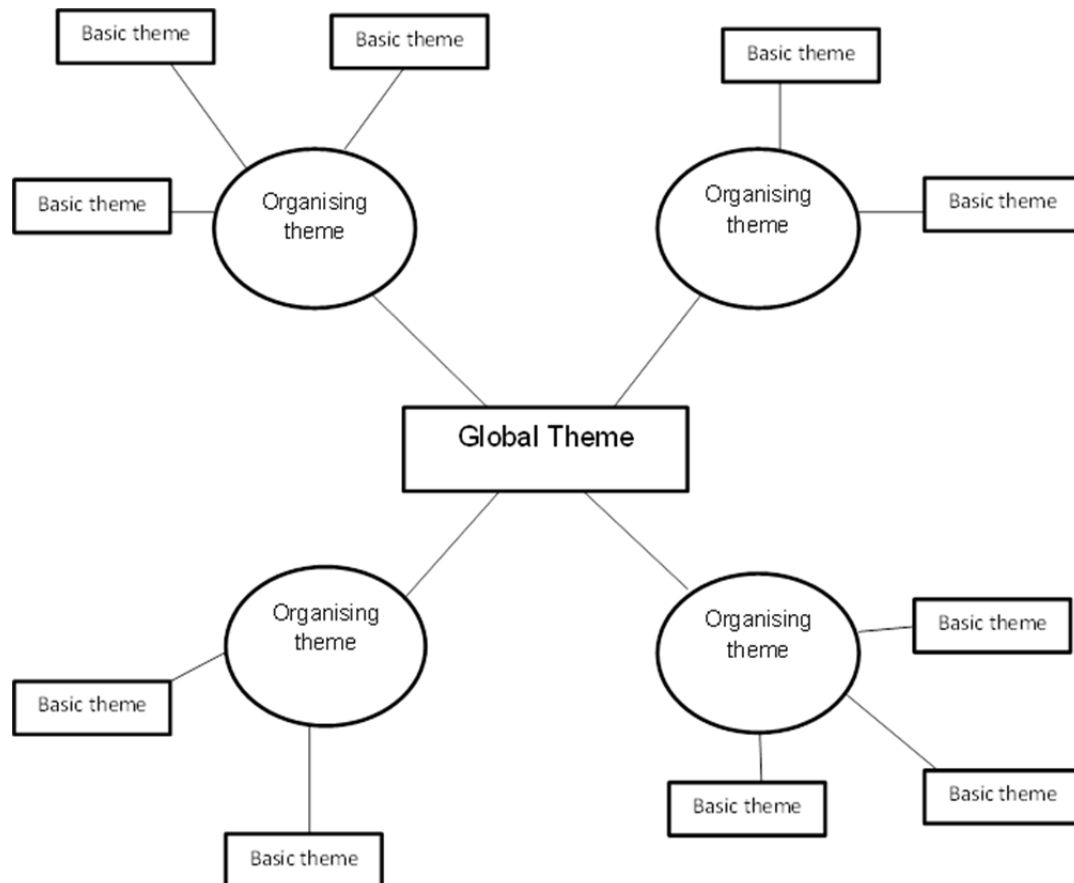


Figure 3.4 Structure of a thematic network (Attride-Stirling, 2001, p. 388)

CAQDAS packages have come under criticism for imparting “mechanistic” and “stereotyped” qualities and as such analysis can become superficial and un-illuminating (Dean & Sharp, 2006). The thematic approach as described above (see Box 3.4) and the process of using a computer package to “analyse” data could be seen as inserting limits to the analysis and imparting quantitative values on to qualitative data. Moreover, they provide a systematic

method for sorting and analysing diverse data sources. Further to this, a second stage to analysis was used to draw out richness and depth from the data. This was again informed by the previous work of Attride-Stirling (2001).

3.8.2 Stage 2: Synthesis and presentation of the data

Once the data had been “fragmented” in stage one, this second stage meant rebuilding the data back up in order to construct meaning. This stage was informed by learned knowledge of the researcher, “embedded” as a project evaluator for two years (Van Maanen, 1979). This allowed project workings to be observed, project workers to be observed and interviewed, and relationships to be built with project beneficiaries and stakeholders. This enabled the realities of working in this environment that is, conflicts, relationships, agendas etc. to inform the research, thus working ethnographically.

To give more depth (thickness) to the data and to enable a deeper understanding the original transcripts were re-read, re-listened and re-analysed. At this stage themes were being explored into greater detail and any patterns/anomalies were extracted. This final stage of analysis meant providing a theoretical underpinning to the themes, patterns and observations and returning to the original research questions.

The use of NVivo is unusual in the construction of ethnographic fiction (no examples were found in an extensive literature search). However, after

consideration, it was not thought to be incompatible. Moreover, its use represents a means to reconcile different research fields, that is, naturalistic and social science. Ethnographic fictions were developed to present the findings in a “truth-like” and “authentic” manner in a way that transcends the reader to experience what the researcher has experienced through the participant that is, presenting “thick” descriptions as opposed to “thin” that just present the facts (Dey, 1993).

These steps were taken to develop the ethnographic fictions:

1. Data was broken down into themes and then built up into thematic networks with subordinate and super-ordinate themes using NVivo (as detailed above).
2. The interconnection of outcomes was explored in relation to wider theory for example; confidence, capacity and agency; gender, mothers and social networks; geographies and food access.
3. Fictional stories were written to present the thick description. They were built up from the thematic networks, linking the hierarchy of themes in a setting that represented participant experiences through the researcher. Details and events were kept, however exact wording from the transcripts were changed to develop a cohesive story.
4. The stories are then used in the discussion of outcomes in relation to the aims and objectives of this research.

3.9 Discussion of methods employed

Reliability and validity are measures of effectiveness in a positivist paradigm. Some positivistic research methodologies assume there is one objective reality, a standard measurement to which results can be measured. In this research it is understood that reality is a construction of the people within it and as such the concept of standardisation and validity has no place. The use of qualitative theory and techniques brings new issues of quality and a new meaning to these concepts in robust research. Thus, requiring a brief discussion here of what meaning these issues have and how have they been understood and allowed/adapted for in this qualitative study.

It is impossible to fix a social setting in place as reality changes over time therefore, it is more difficult for the quantitative concepts of reliability and validity to transcend the two research methodologies (Bryman, 2001). To compensate for this the research procedure has been described in great detail so that, although this may not be replicated entirely, it allows others the opportunity to adopt certain aspects of the research and for the research outcomes to have wider resonance.

One of the criticisms of qualitative research is the large amount of knowledge generated about a very detailed setting that cannot be utilised, due to the difference between research settings and practice. Mays and Pope (2000) argue that the concepts of validity and reliability can be adapted for use in the assessment and utility of qualitative research. Central to qualitative research

is whether participants' perspectives have been accurately and authentically represented, and whether the research can be trusted. Therefore, it is suggested to not abandon all reference to validity and reliability but follow the principles to allow research to be judged fairly. To allow for the social construction of reality and the flexible nature of qualitative research, two alternative criteria have been proposed: those of trustworthiness and authenticity (Bryman, 2001). Moreover, ethnographic fiction provides a universal tool, just not generalisable outcomes. As articulated by Bryman (2001, p. 272), trustworthiness refers to credibility, transferability, dependability (reliability) and confirmability (objectivity). Authenticity refers to the impact of carrying out the research, particularly to representation, education, understanding and empowerment of participants.

Ethnographic fiction enhances the ability of qualitative data to display a sense of context and was used to make sure voices were represented fairly and accurately. Denison (1996) comments that providing a sense of contextual depth in this way it is hoped that enough information is conveyed so that outcomes can be accurately described and transferred to other settings.

Interpretivist frameworks are not used in this research as a compromise but to enhance both paradigms, to acknowledge the limitations of both methodologies and to enable the meeting between different knowledge paradigms across fields of scholarship.

3.9.1 The reflective process

The reflective process in research has been identified in the literature for its ability to build relationships and rapport with participants of qualitative research by bringing to attention the social and cultural factors influencing both (Bryman, 2001).

Due to the sensitive nature of the information required it was important to encourage participants to feel there was a mutual relationship of give-and-take between the researcher and themselves and, for their participation to be a positive experience. Forming and maintaining reciprocal relationships allows the thick, rich, in-depth discussions needed to collect good quality data (Harrison, Lesley, & Morton, 2001; Silverman, 2004). A number of steps were taken to ensure this; interviews were arranged at the convenience and location of choice, a private environment was provided where interviews took place outside of the participant's home, attention was paid to the terminology used and body language, participants were signposted to further support and any nutrition-related questions were addressed. Particular attention was paid to the "power balance" between the researcher and the researched; this was expressed in the clothes worn, the language used to describe the research (simplified but not patronising), the sharing of personal information including social background, knowledge of the local area and family situation. Acting in this way it was hoped that the researcher would be "accepted" enough for responses to be honest and in depth and, that this added positively to data collection.

At the end of each interview with a non-client a fruit and vegetable voucher was given (clients were rewarded for their time by virtue of them being involved in a course provided by the community initiative). It was the intention that those taking part in the research would be provided the opportunity to reflect on practice, understand more about the social influences on food choices and engage with food matters.

Finally, the uniqueness of this multidisciplinary (science and society) research, which is informed by public health nutrition, social science and policy, enhances the trustworthiness of the data. To ensure proper procedures were followed, detailed research journals were kept that evidenced lengthy discussion of theory, researcher reflections and the minutes of meetings.

Chapter Four:

Findings from the Skelmersdale study

4.0 Introduction

This chapter presents the research findings of this project. It provides a description of study participants, an overview of all the themes that emerged from the initial analysis, and the development of these early findings through further analysis and contextualisation for the rest of the thesis.

In order to address the aims of this research, subsequent chapters each present a detailed discussion of findings, using ethnographic fiction as a presentation tool to bring together diverse fragments into a single narrative. This is done so over the three most important and pertinent findings (the overarching global themes). In chapter five the discussion focuses on individual capacity (individual agency and empowerment) as a determinant of food choice, chapter six demonstrates findings that relate to geographical influence on food choice and chapter seven explores food choice as influenced by gender and social networks.

4.1 The research participants

Thirty seven participants (17 clients and 20 non-clients) were recruited and interviewed. Clients had the common experience of having attended a series

of four practical two hourly education sessions focused on weaning and feeding young children, delivered at a range of locations within Skelmersdale over the previous two years of SCFI operation (details of the community initiative are in Appendix F). All the interviews were performed in Skelmersdale either in the home of the interviewee (n=23) or at a local Children's Centre/Community building (n=14). Socio-demographic data for each participant was collected during the course of the interview and is as follows.

The study participants (clients and non-clients) were all women aged between 20 and 39 years. Most participants were married or living with their partners (n=31) and had lived in Skelmersdale all or most of their lives (n=22), none had lived there less than 1 year. Most participants had either one or two children (n=34) and the majority were unemployed/"at home parents" (n=22).

Data collection began in April 2007 (excluding July and August 2007 when data collection was postponed for school holidays), and continued until December 2007 when it was determined that no new themes were appearing and the same themes were being repeated, therefore saturation of the data had been achieved.

4.2 Findings from the thematic analysis

Although data from clients and non-clients were analysed separately, the similarity between the groups in terms of the range of themes emerging

enables the findings from both groups to be presented together. Figures 4.1, 4.2 and 4.3 present all the themes derived from the first stage of analysis. The themes - presented as three figures - are interrelated, so are not intended to “stand alone” but to form a three dimensional picture of food choice influence.

The first of the figures, 4.1, represents the relationship between participants and the built environment, both macro and micro influences. Micro level influence was determined as the home and kitchen environment, the facilities available to the mothers, and how they felt these might be an enabling or a restricting influence on food choice. The macro influences were determined as the influence of place and outside geography, for example, ease of mobility, open space, and physical barriers to food access.

Figure 4.2 presents the themes relating to the “lived environment” which are participant’s experiences of living in the built environment. Themes here related to respondents feelings about the area for example, their personal safety, unseen area boundaries, being from Skelmersdale or moving to Skelmersdale.

Figure 4.3 presents the themes relating to participants and their ability to “perform” within both the built and lived environments; the importance of family, income, gender and individual capacity.

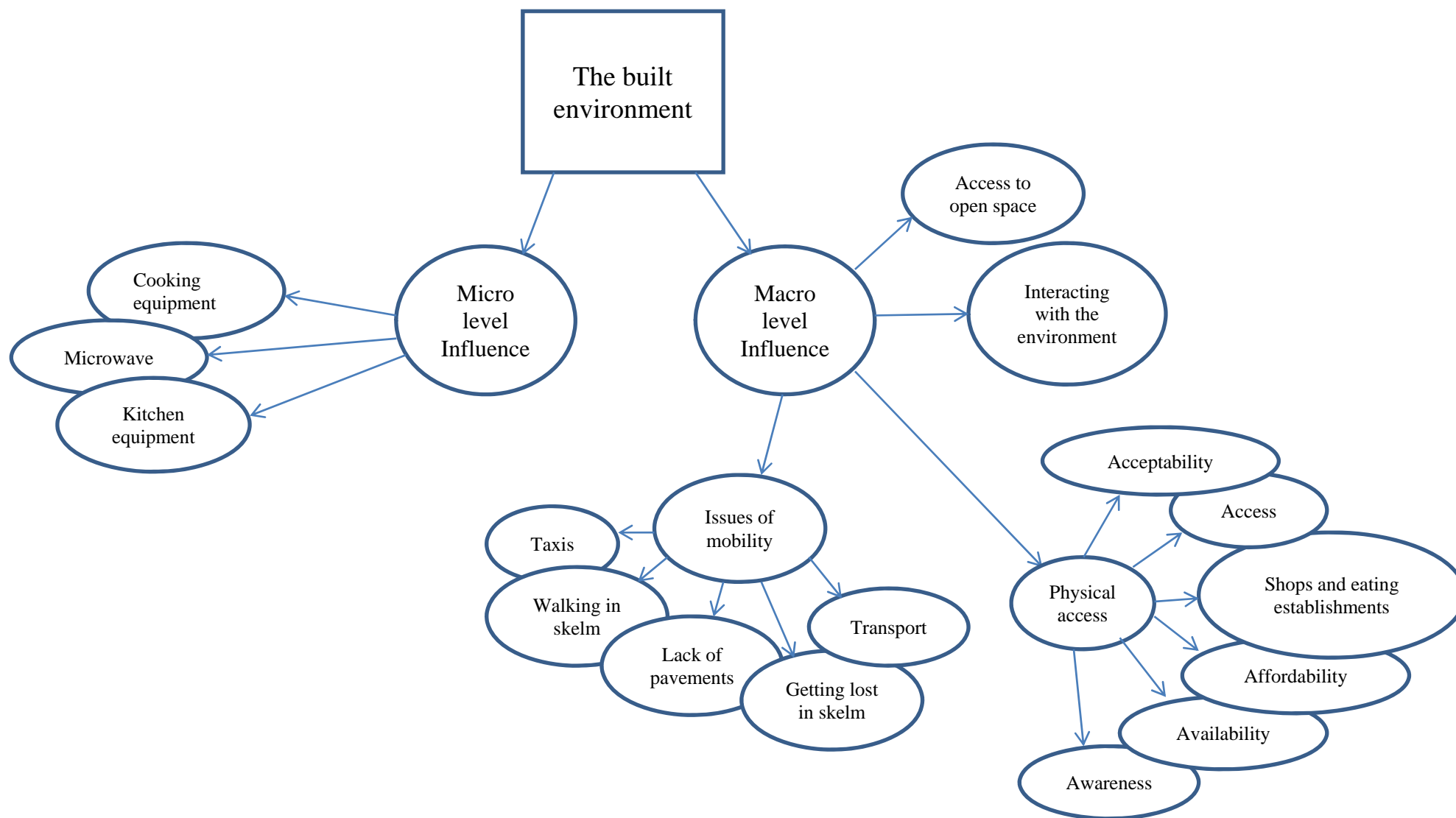


Figure 4.1 The network conceived through thematic analysis of the data relating to the built environment.

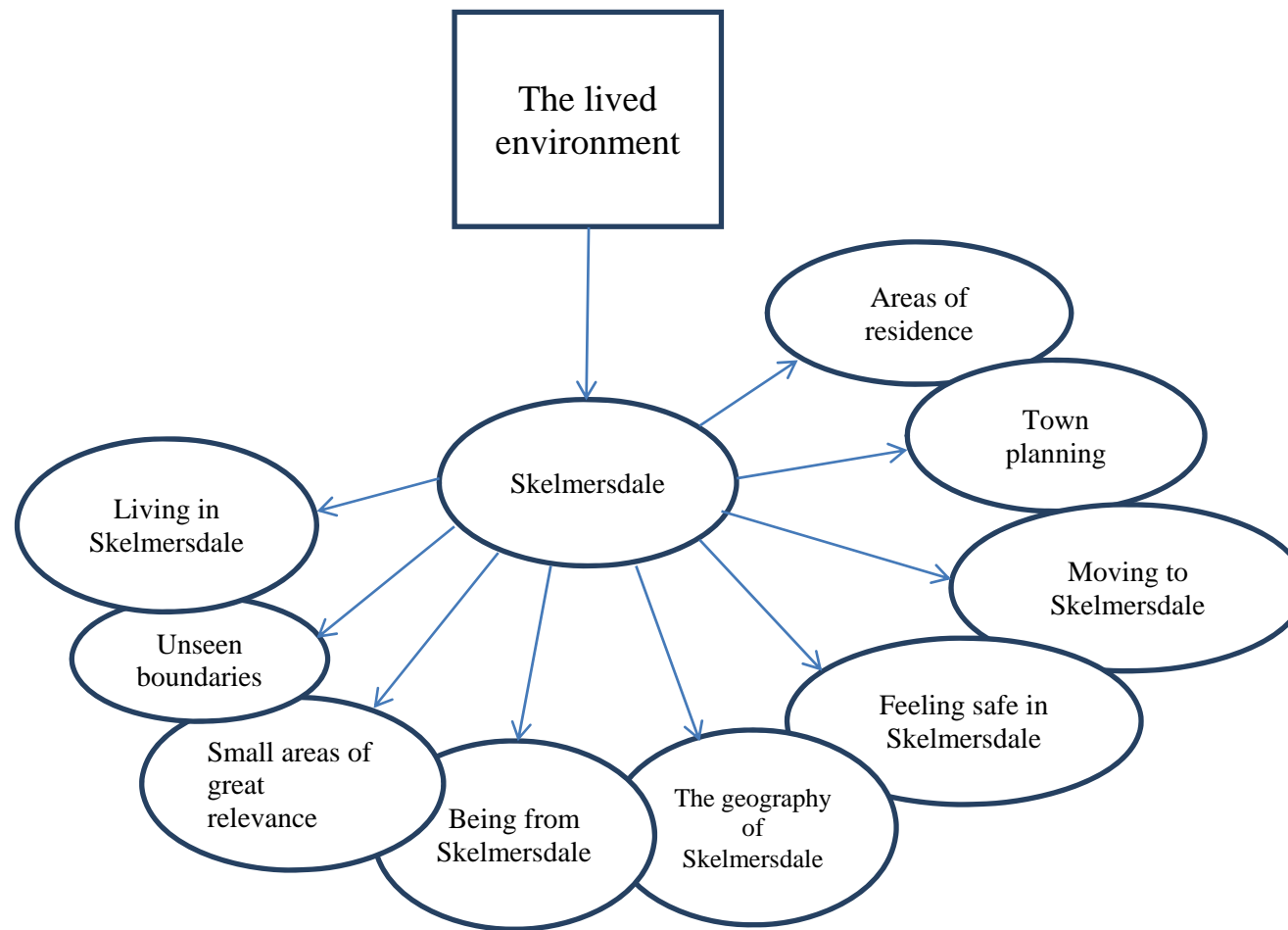


Figure 4.2 Food choice influences relating to the lived environment in Skelmersdale

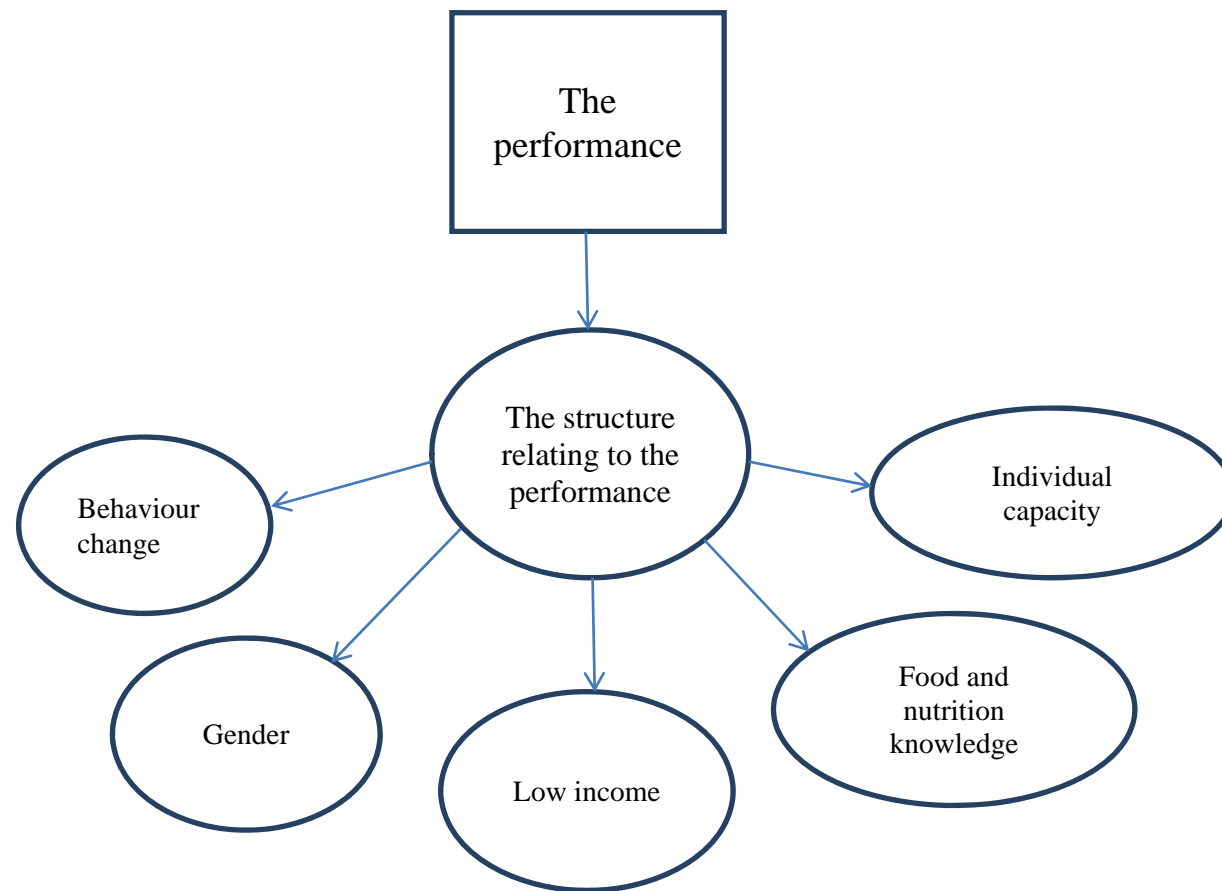


Figure 4.3 Themes relating to the performance of participants in connection with the built and lived environments

4.3 Hierarchy of influence

As explained in section 3.6.1., in order to explore and develop a natural hierarchy of influence on food choice that was emerging during the interviews, a pile sorting exercise was introduced. The pile sorting exercise enabled the discussion of positive and negative influences on food choice and of influences that are either conservative (limit new action) or progressive (instil new action). The following excerpt gives an example of how the pile sorting exercise was used during an interview with a non-client (NC), aged 32, mother to a 12 month old and an 8 year old.

RG: "I've got some cards here of what people have said have influenced the way they eat, it might apply to you, it might not...So, when you were ready to wean your children, how did you feel about the nutritional advice that was available to you?"

Participant: "I think from when [first child] was little to now it's change completely whereas when [first child] was little you could give them peanuts, you could give them like all sorts of other stuff whereas now they're saying don't give them nuts, don't do this, don't do that, and I'm thinking "well it didn't do [first child] any harm so I will" so I just ignore their advice and just give them stuff that you're not meant to" (NC05)

And as the interview progressed;

RG: "...You're a fairly confident cook [and as you explain it] that's come from your mum and your dad?"

Participant: "I never buy ready-made meals, never, my mums never bought them so I've never bought them, and whereas I think if I was brought up on ready meals I would, whereas I haven't so I don't buy them at all". (NC05)

From the short extract it can be seen that, for this participant, the more important influence was her parents and the food she was given growing up and the less important influence was the conflicting nutritional advice from health professionals that she stated she ignored (photographs of the pile sorting exercise can be seen in Appendix E).

Figure 4.4 presents the themes as a hierarchy of influences on participants with respect to the food choices they make. This figure displays all super-ordinate themes from both clients and non-clients in order of importance. As can be seen in the figure, the main influences on food choice (as determined by discussions relating to how constricting or how enabling influences were towards a healthy diet) related to the mothers individual capacity, becoming a parent, social and community networks and the geography of Skelmersdale. Factors that generated much discussion, but were deemed less influential on the food choices, as they came secondary to the above, involved the production and consumption of a "healthy diet". These were, nutritional knowledge, cooking skills, along with awareness of nutrition and health issues and cooking confidence. Time to shop, prepare and cook meals, affordability

of a healthy diet, the acceptability of foods available, the quality of foods available and other discussed influences, such as being a vegetarian or having a nutrition related illness, were shown to be less influential and so were placed further down the list of importance.

Unique within these findings is the indication of the hierarchy of influence. Here, it has been possible to identify qualitatively the importance of these factors, which further contributes to the thinking on the wider determinants impacting on food choice (Wanless, 2004).

Three main areas of food choice influence were identified in the hierarchy that is, individual capacity, influential others (social networks) and the geography of an area. These themes are examined closely in the following chapters where a deeper analysis exposes the current gap in the literature. Most prominently, the influence of individual capacity on the food choices made by mothers of young children is discussed in chapter five. Secondly, gender and relationships such as social support networks and parenthood influencing food choices is the focus of chapter six. Thirdly, the issue of “place”, for instance town planning, the geography of an area and interaction with diet is the point of interest in chapter seven.

It is important to note that this research aims to open further the debate around health policy, how it is developed, implemented and evaluated and therefore guide practice with respect to PHN. The research in Skelmersdale provides a unique opportunity for debate on “food as a medium for social

change” using community development theory, by looking at previously under-developed themes in nutrition research such as capacity, social networks and geographies.

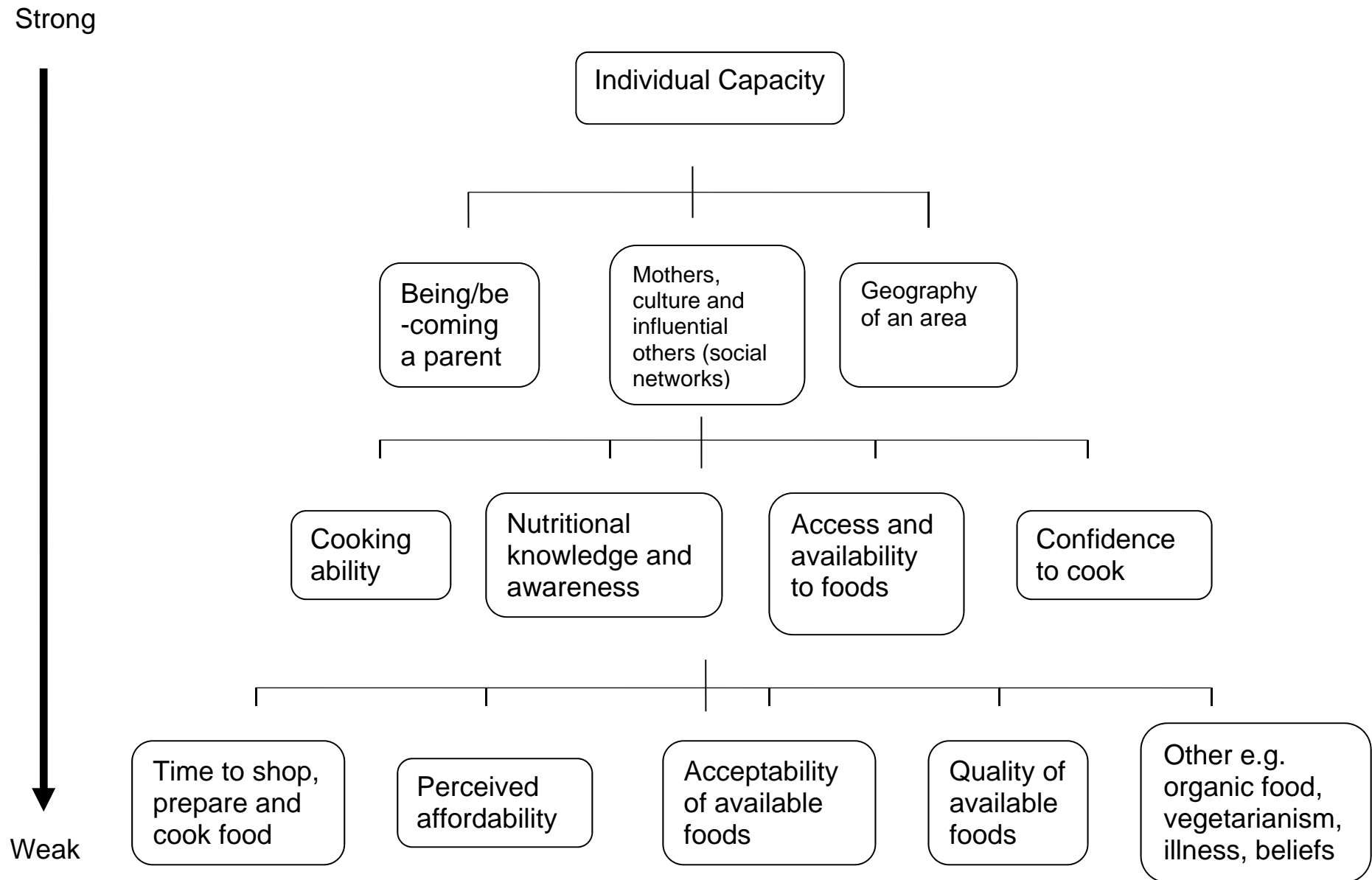


Figure 4.4 Hierarchy of food choice influence

Chapter Five:

Individual Capacity as a Determinant of Food Choice

5.0 Introduction

In this chapter ethnographic fictions (see section 3.2.1) are used to present the themes. The use of ethnographic fiction allows views to be accurately represented as they have been expressed, to present a number of narratives as gathered from client and non-client participants (Watson, 2003). The themes presented in this chapter are those of, becoming a parent and the impact on food choice, nutritional knowledge and cooking (skills, ideas, confidence) influences, individual capacity influences for non-clients, individual capacity and the role of the community food intervention for clients. A discussion of outcomes follows each fictional representation that draws together wider empirical and theoretical research and debates the implications of findings.

5.1 Ethnographic fiction: Presenting voices

Ethnographic fiction (EF) is used in this research as a tool to bring together diverse fragments of interview, researcher experience and observation into a singular narrative. EF is used to create a “conversation” between singular accounts to present a number of themes. The narratives then reveal a thick description of a life-world that would not necessarily present itself solely

through displaying interviews as separate comments. The fictions also allow a reflective element, and where interviewees were not as articulate as others were, the fiction provides the sociality that is consistent with the aims of CD, giving voice to the unrepresented/"silenced groups" (Sparkes, 1997).

In the ensuing chapters, ethnographic fictions illustrate either a number of themes at once or singular themes. In some cases, the fictions are quite lengthy and the "characters" feature more prominently, in other cases comments are just used to illustrate one observation or theme. However, the continuity of the same "characters" throughout these discussion chapters aims to build up a story of their lives and views. The stories provide a fictional journey, though one that is not so far from the many independent interactions and experiences of the researcher during the research process and time spent in Skelmersdale, so as to give thick descriptions of the intervention and the person (Sparkes, 2002).

5.2 Becoming a parent, nutritional knowledge and cooking ability

There was an expression of uncertainty about food across the participant mothers which was consistently reinforced, either in the desire to "get it right" or conversely, not to "get it wrong" for their children. Participants were uncertain about many aspects of child weaning or feeding and were either seeking information or looking for reassurance that their food choices were correct. Laura regularly attended an infant and toddler group. She was part of the non-client study group, so did not attend the community intervention.

Laura's son was approaching 18 months old, she talked about some of her experiences of weaning;

When you're a new mum you don't know nothing and you're scared of doing the wrong thing. Looking back I'm absolutely gutted, I struggled with weaning I really did, I took the easy option out with jars and I am absolutely gutted about it now. All you want is to give them the best start but the poor child was fed nothing but either jarred food or mash [potatoes] and plus there was that big scare out, you know about the gravy with too much salt. It really really frightened the living daylights out of me and I would not try him with any of the food, I'm being really honest here, I sound like a lunatic. I didn't want to get it wrong and then 20 years down the line he [son] has something terribly wrong with his intestines. I wish I'd had someone there to show me what you can and can't do, I really really do because there's no reason why you should know all these things until you become a parent.

Kathryn (non-client) attended one of the children's centres, she is thirty-one, has two children under five and has lived in Skelmersdale all of her life. She talked about her views on healthy eating and of the importance she places on her children's diet, and some of the restrictions she puts on it;

For the kids, they're allowed cereal in the morning and nothing else, so they'll be getting their milk and I don't like them having sweets or cakes or crisps or nothing. I do let them have them

now and again as a treat but I don't want them to wreck their teeth or to bloat with the fats and sugars or anything and I don't want them having all the E numbers and sugar from the sweets and the juice. I'm not that bad that I go round checking the back of everything [food labels], but I do check for the E numbers. I've cut them out completely because I know it can make him [son] hyperactive and I look for the amount of salt and fats in things more than anything else, otherwise you'd be there for hours reading them you know. I try and make sure they have their "5 a day" and I don't let them have microwave meals of anything. I have them, but they can't! It is for the kids, I try and get them to eat a lot better than me because I know it's about getting them into a routine of eating healthy before they get older themselves...it's just making sure that they're fed, and getting the right amount. I know sometimes they don't get the right amount of veg that they should have on there but I try and it's hard if they're being fussy.

What was becoming apparent was the need for specific information relating to weaning. Sandy and Terry both make this point,

Sandy: I mean everybody knows fruit and veg and everything is good for them but you know like to make it up into a meal for them [child] that they can eat it, I find there's no information whatsoever on that type of thing, you know like I've struggled. I wanted him [son] to eat fruit but I just didn't want him sat

there eating fruit I wanted to make it into different things for him so he doesn't get bored but there is a real lack of information on what type of meals to prepare. (Non-client, mother of one)

Terry: I knew I didn't want to give her jarred foods, I've always wanted to give her my own food but I didn't know how to go about giving her me own food or how to introduce it or when to start weaning or when to take the bottles away from her. (Client, 26 years, mother of one)

This feeling of uncertainty was further compounded by the amount of conflicting nutritional messages directed towards the mothers. The amount of information available meant that even Government recommendations lacked credibility. Sue has two children, one aged eight years and one eight months;

I think from when [first child] was little to now, it's changed completely: whereas [before] you could give them peanuts, you could give them like all sorts of other stuff, now they're saying don't give them nuts, don't do this, don't do that, and I'm thinking "well it didn't do [first son] any harm so I will", so I just ignore their advice and just give them stuff that you're not meant to. (non-client, 32 years, mother of two)

Kathryn comments;

You're bombarded with it constantly, any magazines or different things to do with parenting you know, you're bombarded with it you know "are you doing this right" and sometimes you have to switch off and ignore it and try your best haven't you...There's all sorts of conflicting advice like you shouldn't have too much chocolate and then suddenly it's helping to cure cancer you know, if you listened to everything you'd never eat! (non-client, 31 years, mother of two)

Kate comments on the issue she has with label reading;

They [food companies] usually replace fat with sugar or sugar with fat or it's low in calories but has loads of salt in it. I just want to be able to pick something up and go "right that's got that, that, and that in so that's no good, but that's ok" and get on with your day because you haven't got the time especially if you have got more than one [child], it's hard work. (non-client, 28, mother of one)

With the concern of "additives" and not knowing "what was in" convenience food, cooking from scratch was a priority for the mothers. In a few cases it was felt that basic cooking skills were completely lacking and in these cases participants avoided cooking, so their partners cooked or they relied (sometimes unwillingly) on convenience foods. Kate had used convenience

foods before becoming a parent and was reluctant to carry this on at the weaning stage;

I didn't want to have to rely on the ready meals, I didn't want to keep them in the freezer so I'm not tempted to just bung them in the oven, sometimes you might have to but ... I know obviously babies don't eat ready meals but jars can be the equivalent of them can't they. I'm about to wean her and I think it's important that she eats what I eat, I mean obviously I really don't want to buy jars, but again sometimes you might have to but wherever possible I won't give her anything I wouldn't eat. (28, mother of one, non-client)

Angela didn't class herself as a confident cook, she comments;

I'm no master chef, I can cook but it's getting everything done at once, like the potatoes will be done before the carrots you know, something's always cold on your plate. I'm a very basic cook, I'm very much a shepherd's pie, bangers and mash, roast dinner, salads, jacket potatoes, stews, that kind of thing.
(Client, 26 years, mother of one)

The mothers felt that they possessed basic cooking skills but particularly wanted to know how to prepare foods for weaning, wanted a point of reference to discuss practical issues, cooking ideas, and have the confidence to know they were "getting it right". Angela comments;

If you don't know what to do with food, you just don't think, because once you've seen it then you think "why didn't I think to do that?" and "I wouldn't have thought to give that to a baby? It's not until somebody is there and shows you that you know you can do that sort of thing. (Client, 26 years, mother of one)

Tracy comments how she finds it hard to provide a healthy diet for her son, who is twenty months old;

I get frustrated, I wake up thinking what am I going to cook today and I find myself getting really stressed out, I just want his diet to be balanced and sometimes I run out of ideas.
(Non-client, 27, mother-of-one)

Mothers were greatly aware of the responsibility of providing a healthy diet for their children. Parents indicated the amount they worried about food choices and making sure they made the right choices. In recent research parents (mothers) have been shown to hugely influence the healthfulness of a young child's diet (Musher-Eizenman, Lauzon-Guillain, Holub, Leporc, & Charles, 2009; Pearson, Biddle, & Gorley, 2009). Parents have a significant role in terms of the types of foods children are exposed to, the types of foods restricted, the nature in which foods are presented (either in a positive or negative context), the development of food likes and dislikes, a child's predisposition to obesity and body (dis)satisfaction (Crombie et al., 2008; Kalinowski et al., 2011; Scaglioni, Salvioni, & Galimberti, 2008; Swanson et

al., 2011; Wardle & Cooke, 2008). The uncertainty of knowing what to do as a parent with a young child was attributed by the mothers to a lack of nutritional knowledge. A very strong repeated theme was this reference to “not knowing”, not wanting to “get it wrong” or a real desire to “get it right” so as not to cause health problems in the future.

A second very common theme was the mothers reporting a lack of nutritional knowledge. However, despite some issues with accuracy, nutritional knowledge did not appear to be lacking. When explored, most mothers held correct views of what was and was not a healthy diet. Research findings from the literature suggest that the general population does understand what healthy eating is and that most know the recommendations for portions of fruit and vegetables, albeit at a “semi-qualitative level” (Crombie et al., 2008; Dibsall, Lambert, Bobbin, & Frewer, 2002; Goode, Beardsworth, Keil, Sherratt, & Haslam, 1996; Lobstein & Davies, 2008). It would appear from this research that the general understanding of a healthy diet is the inclusion of five portions of fruit or vegetables a day and an avoidance of salt, fat, sugar, “E-numbers/additives” which parents attributed to obesity, tooth decay and the child’s poor behaviour e.g. hyperactivity.

In the same instance as reporting a dearth of suitable information on child nutrition, the mothers reported being “bombarded” with nutritional messages, from the media (magazines, television), food companies in the form of food labels and advertising, and supermarkets. Mothers were left either in a state of confusion or of apathy. As Buttriss (2003) states;

the public is bombarded daily with advice on a multitude of aspects of diet and nutrition...which are at best confusing, often conflicting, frequently not based on good quality evidence and at worst base on frank misinterpretation or misunderstanding (p. 573).

Research from Basu and Hogard (2008) found that UK tabloids were particularly inaccurate and unbalanced when reporting nutrition research. This produced a largely negative attitude towards nutritional messages, leaving the Skelmersdale mothers with feelings of confusion and scepticism as displayed in the fictional examples from Sue, Kathryn, Angela and Kate.

Without an obvious reference point or source for information on child diets, mothers found themselves referring to food labels and supermarket leaflets (as one participant commented, “those ones dotted around the shelves”). As UK consumers rely more on packet/convenience foods, food labels have been the focus of health promotion efforts to inform healthier choices for British consumers (Lobstein & Davies, 2008). Despite this, suggested food labelling systems are still just a recommendation to the food industry and, as Boggott (2000) explains, are unlikely to be a good source of information due to the commercial interests of the food and farming industry. Likewise, supermarkets, with an obvious commercial gain may not be the most appropriate sources of nutritional information. As was discovered here, mothers found label reading time consuming and would appreciate the ability to know “at a glance” the nutritional quality of a product.

As discussed in earlier chapters research has demonstrated the importance of nutritional knowledge, linked with healthfulness of the diet independent of education level (Dallongeville, Marecaux, Cattel, Bingham, & Amouyel, 2000). Having a basic understanding of behavioural risk factors is important in the change process, if people mistakenly think they have a “good” diet they will not be motivated to change (Dibsdall, Lambert, Bobbin, & Frewer, 2002; van-Dillen, Hiddink, Koelen, Graal, & van-Woerkum, 2008). However, in terms of public health nutrition intervention, traditional approaches that “educate” populations have been relatively ineffective. The link between improved nutritional knowledge and behaviour change has considerably weakened as the complexity of cultural and socio-economic influences have taken precedence (Crombie et al., 2008; Dallongeville, Marecaux, Cattel, Bingham, & Amouyel, 2000; Goode, Beardsworth, Keil, Sherratt, & Haslam, 1996; Kennedy & Ling, 1997; O'Neill, Rebane, & Lester, 2004; Wardle, Parmenter, & Waller, 2000).

As well as reporting a lack of nutritional knowledge, feelings of a deficiency in cooking skills or in the time available to cook “from scratch” were common themes for non-clients and for clients (clients talked retrospectively). Despite these concerns however, it would appear that mothers could accurately demonstrate what constitutes a healthy meal and basic cooking skills, but lacked confidence in their ability. A lack of cooking skills and the time to cook healthy food have been previously noted as mediating factors in an unhealthy diet for mothers on low-income (Caraher, Dixon, Lang, & Carr-Hill, 1999;

Dubowitz et al., 2007). However, on further investigation it appeared that the mothers were not so much lacking in cooking skills, but lacking in confidence in their ability to cook and thus provide a healthy diet for their children. These findings support what is already known on food choice (discussed in detail in the opening chapter) which showed that a lack of confidence to cook can be just as detrimental to diet. In a cross sectional survey of men and women in the UK, Lang and Caraher (1998) showed that skills profile was not different between low income and high income groups. However, low income groups reported less confidence in cooking skills than high income groups due to economic pressures, for example, not wasting food or not feeding the family sufficiently (Lang & Caraher, 1998). In an large Australia sample (n=932), Thornton, Jeffery and Crawford (2011) found the confidence to shop for healthy foods was a key factor for a high frequency of fast food consumption for women living in socio-economically disadvantaged areas. Furthermore, Short (2002) suggests that the confidence to cook is as important as the ability to cook for the part they play in the “healthy eating jigsaw” (Stead et al., 2004), which equally supports the findings of this hierarchy of food choice (Figure 4.4).

The importance of healthy eating for the child and not for the parent was a strong theme among mothers from both groups. Conflicting priorities meant that the health of the parent was not deemed as important as health of the child, for example, statements such as; “[they] eat better than I do, definitely” were common. Although scarcely reported on in the literature, this supports findings from some previous research, where the diets of women from the

most disadvantaged circumstances were compared with their children and were found to be consistently poorer (Macintyre et al., 2003). The findings from the women in Skelmersdale are also in agreement with wider gender studies which demonstrate that women, regardless of ethnicity, prioritise the needs of their partner and children before their own (Charles & Kerr, 1988; Ludwig, Cox, & Ellahi, 2010). This is further explored in chapter six.

There were a number of factors that joined together to negatively affected participants food choices. Knowing the importance of a healthy diet, wanting to provide it for their children, in addition to a feeling of inadequate nutritional knowledge, a lack of skills and a lack of confidence in their ability left mothers feeling incapable and disempowered (discussed in more detail below). This meant that mothers who, wanted to cook from scratch, avoid convenience foods and “know what was in” food felt unable to, at a loss for ideas, and in some cases having to succumb to convenience weaning foods. The themes listed here represent a “window of opportunity”, or a point in the life stage where mothers are motivated to implement healthy dietary practices (make changes where necessary), are seeking information, verification/reassurance and support from an appropriate non-conflicting source.

5.3 Individual capacity and non-clients

Scarlet (non-client, 25 years old, mother of one), lives in a housing estate typical of the “new” Skelmersdale area - a large concrete building divided into flats with a numbering system found by local residents to be confusing (“all the

odds in a different building to the evens"). Scarlet has a small basic kitchen leading into the main living area. The living area was sparsely furnished, had a television in the corner, a few children's' toys and the floor was uncarpeted. Scarlet is not working, lives on her own and has a two-year-old daughter who she is keen to mention "is not a fussy eater, she's been brought up that whatever I eat, she eats". Scarlet has made some dramatic changes in her food choices since becoming a parent. She explains the thoughts and processes involved in feeding herself and her daughter;

The thing is you don't know what to believe, they all say different things and send mixed messages out. We eat fruit, veg, and proper meals so I don't have to worry about the rest, the salt and the fats and that. I'm quite good at cooking and because she's not fussy I can be quite adventurous. I cook everything myself, that's why I never bought a microwave, if I had a microwave I would just get a microwave meal and stick it in the microwave. And that's why I chose not to have a microwave because I knew we'd both be getting proper food and it makes it a lot cheaper to cook proper food than it does microwave meals. I don't like the idea of giving her [daughter] microwave meals, at least when I'm cooking it myself I know what's in it. Before I had her I used to live on microwave meals, I was quite happy living on my microwave meals but I thought if she sees me eating them things she's not going to like other things, so I started eating fresh fruit and veg and she likes it all now. And they're [microwave meals] not healthy at

all, they're quite fattening, if I'm not healthy I'll not be able to look after her and she won't be getting what she needs, so I have to look after myself so I can look after her. When she was ready to be coming on to proper food I stopped using a microwave and I started cooking veg and mashing it all down because it's the best thing for her, there's no additives or anything in it it's just what you put in it. I didn't want her to have any umm salts or anything like that in her foods. She was a hungry baby you see, she had to have proper food early because the milk wasn't filling her up and I didn't want her, because she was so young and her body wasn't developed, I didn't want her having anything that would make her unwell so that's why I had to make it. It was to do with my health visitor. She used to come round a lot at first and she explained how it's easier to mash everything down, but then when she [daughter] got past that stage I went to the library and got recipes out the library so I would be able to make my own foods and things to make it more appetising for her. It is time consuming it is, because when I've finished a full day with her and then picked the kids up [Scarlet looks after her niece and nephew after school] the last thing you want to do is cook a big meal so it would be the easiest thing for me to do is go to the freezer and get out a microwave meal. But that's why I never got a microwave so that I would still have to come in and do that. She [daughter] goes to bed dead late and gets up

dead early and I'm tired all the time and I still come in and she still gets her meals. It depends how much you want your daughter to grow up healthy, if it is important to you you'll do it, if it's not, you'll give up. There is a lot of people that aren't that bothered because I've seen hundreds of kids in that Coni [local shopping centre] stuffing their faces with pasties, McDonalds, chippies and it's just that it's easier, they don't have to do it themselves, they just go and buy it and it's sorted. Junk food makes you lazy, it's got nothing in it and more often than not when you've had something like McDonalds a couple of hours later you're hungry again, whereas when you have a roast dinner you're full or pasta, you're full. My friends' son just sits in front of the tele all day and will only eat sweet foods. I never let her have them jars of baby food or them jars of chocolate pudding, I didn't want her having all the sweet foods, I kept to the savoury at first because if you taste the sweet before savoury foods then that's going to adjust your palate. And now she prefers savoury foods and she won't sit in front of the tele, she's never been put in front of it, I want her to be more active.

For Scarlet becoming a parent came high up on the list of influences on food choice and as such acted as a catalyst for wanting to provide a healthy meal for her children and family. Scarlet is one of the non-client respondents who felt confident and capable to transfer these intentions into actions. Jody is

twenty and has a two year old daughter, she is not working but volunteers two days a week at the Childrens Centre in Skelmersdale. I interviewed her at the Children's Centre and I ask her if she thinks much about healthy eating when planning her meals at home;

I never look at food labels I don't do that, that's one thing I've never done is looked at labels or thought "I'm putting too much salt in that" and stuff like that, I've never done it, which I know I should but it's just something I haven't done. I would probably be scared of what's in it and stuff like that, and then I'm going to sit down and eat it and it would probably put me off or something, life's better if you don't know! I do try to think about healthy food but I'm not that good at it [laughs]! She's [daughter] just a really really fussy, picky eater. It's very hard work. I'm always trying to get healthy things down her but she prefers to just like go to Mc-ies [McDonalds]. Chicken nuggets and milk shakes, basically that's all she'll eat. I'll go in there and I'll think right I'll get her some carrots and some fruit but she's not gonna have it, cos at the end of the day it's a burger place, it's always going to be a burger place and she's gonna want the burger cos she's gonna see other people eating burgers and chips and things like that and so. I try my best not to go in there that much but if we drive past and she sees it, it's like "Donalds! Donalds!" and it's like "just swing in quick and get her something for her dinner or something... I try and get healthy stuff down her but there's no point in me buying it if

she's not going to eat it. She'll only eat pasta and fruit, that's the only thing that she will eat really. She's not a breakfast person, the amount of times I've done her breakfast that she won't eat, so then I tried her with a yoghurt and she wouldn't eat that for breakfast so now I've got her on fruit but the only fruit that she will eat for her breakfast is a plum and that's it, that's all I can get down her, is a plum. I don't really eat breakfast myself, I'm more sit down with a cup of tea or something and it could be that, with her not seeing me having breakfast she's thinking "well, if me mums not having it I'm not going to". I didn't think about healthy food until I was pregnant and I'd had the baby. While I was pregnant, I thought "I don't want to eat that cos it's not fair on the baby" or "the baby needs healthy foods so I'm going to have to eat healthy", and not so much I have to do it for the baby but I need to do it for me as well cos it's better for me to be healthy as well in the long run. I sit there and think "right, alls I'm going to eat this week is healthy food" but then the week after it'll be out the window, either I'm busy or I can't think of anything to have. I'm a terrible cook, everyone always tells me I'm a terrible cook, I think that's because I don't try and cook, I just bung something in the oven or I put some-at you know in the microwave. And then when I do try, with that little bit of time I've got, I'm still rushing it. Basically it's due to not having enough time and knowing actually what to do properly.

Sandy is thirty-seven and has lived in Skelmersdale for twelve months, she lives on a small row of houses in an industrial area of Skelmersdale. She comments "it looks just a road in the middle of an industrial estate but this is actually the old road to Wigan before ASDA and all the estates over there were built, this roads been here forever". It is Sandys son's first birthday today, whilst rushing round preparing the house for guests, she talks about the sort of weaning information she received;

I'll tell you what I do find, we haven't got much access to information on what's good to give [a baby]...I went hunting round all the book shops I could find until I found baby books with different stage baby meals in you know, really it was like what veg goes with what from the early stages, things like butternut squash and that type of thing, I wouldn't have had a clue what to do with it. You can't get that, even off your health visitor it's like "oh they need fruit and veg". I know what they should be having but what to do with them that's the thing. There was a real lack of information and it was so hard to get it. I just went off on my own, looked on the internet got different recipes, and from my friends. You know, I don't want him to be like me, fussy and go "oh no I'm not eating that" I want him to go "oh I'll try it, I might like it"...I had to go to Southport for the information, because to be honest with you, I didn't know my way round here, it was very awkward. It's different if you're on the estates, but our health centre is over

there and there's nothing over there, I went to a few of the groups and everything there but there was nothing really on nutrition.

Whilst most non-clients reported a lack in practical weaning knowledge and cooking skills, there was a distinction between interviewees who actively sought out information (from books, friends, health professionals, the internet, food labels and supermarket leaflets). Like others in the non-client group Scarlet and Sandy felt their practical knowledge of how to wean or feed their children was lacking, but unlike others, they actively sought this kind of information. They found the information from their health visitors fell short of what they required and so referred to other sources (e.g. books, the internet and friends).

The main comparison between the accounts by Scarlet and Jody would appear to be related to a level capability or capacity to demonstrate control and problem solving ability with regard to nutrition within a challenging situation. This deduction stems from the observation that non-clients and clients alike stated that, where “problems” were presented, they were either capable or not capable to overcome them to make healthy food choices. Becoming a new parent appeared to present a “window of opportunity” for dietary change. Mothers were either empowered at this stage and sought information from various sources or, felt constrained and consequently wanted to make changes but did not know how, which left mothers feeling disempowered.

The World Bank (2011) defines empowerment as “the process of increasing capacity of individuals or groups to make choices and to transform those choices into desired actions and outcome” (“The World Bank definition of Empowerment”, 2011). In the context of community development empowerment describes a way of working which attempts to increase people’s power or capacity to change. The suggestion that empowerment can have a direct effect on health comes from policy documents from the World Health Organisation who describe empowerment as a pre-requisite for health (Aymé, Kole, & Groft, 2008).

The account by Scarlet (see section 5.3) exemplifies the notion that a significant degree of individual capacity was the reason for making changes and becoming a parent, the main catalysts to have brought this change about. The use of the phrase “individual capacity” here is in agreement with the definition of empowerment by The World Bank (2011) but goes further to describe a person’s confidence, perceived control and ability to problem solve despite outer social and cultural influences. As shown in hierarchy of influence (Figure 4.4, Chapter 4) other influences such as knowledge/awareness, time, affordability and child food preferences appear to have an impact on food choice and are nonetheless important but appear further down the hierarchy for individuals with a strong sense of individual capacity. For example, these “lesser” barriers can be overcome by someone who feels they are “in control” and able to problem solve (see section 5.3). Conversely, the description given by Jody shows that, without any degree of individual capacity the influence on

poor food choices appears to be great and the influence of lesser factors that is, time, affordability, cooking skills, appear to be more pronounced. The reasons listed as important were the time available to prepare and cook healthy meals, their cooking skills, whether it is safe to cook around a child and the child's food preferences. Furthermore, with a low degree of individual capacity, any attempt to implement dietary change appears to be short lived. This left mothers feeling "frustrated" and "stuck" as reported by Tracy (see section 5.3) and were more detached from the importance of a healthy diet.

Food choice influences go beyond the development of basic knowledge and skills argument. Individual capacity relates very well to the psycho-social models of control and self-efficacy. Barker, Lawrence, Woadden, Croziera and Skinner (2008) investigated the predictors of diet between women of lower and higher educational attainment in the UK. The authors found that for those of a lower educational attainment experienced a lack of control over food choices in the household, and this to be a dominant underlying influence that ensued from a combination of wider social environmental and historical influences such as cost and waste, shopping and food access, skills and experience. As Lawrence et al. (2009) argue, "Individuals only feel in control of a situation if they believe they have a degree of self-efficacy, that is, the ability to carry out an action; if they do not feel in control, self-efficacy is lower (Walker, 2001)" (in Lawrence et al., 2009, p. 1016). Lawrence et al. (2009) goes on to suggest that a reduced sense of control and self-efficacy can have negative effects in terms of the success of attempts to eat better, as exemplified in Jody's account (see section 5.3).

Barker, Lawrence, Woadden, Croziera and Skinner (2008) and Lawrence et al. (2009) were able to link poor dietary choices to low educational attainment and thus control and self-efficacy (but to a lesser extent). This current research solely investigated the dietary influences of mothers of young children from a (relatively small) deprived area of West Lancashire and did not explicitly investigate women with lower educational attainment or low-income for that matter. Therefore, the researcher is not able to make any generalisations or conclusions on the relationship between educational attainments or socio-economic status and food choices as no clear pattern emerged from the data. However, as the fictional examples from Scarlet and Jody demonstrate, women from very similar situations consistently exhibited contrasting views on food choice influences. Barker et al. (2008) argue that this is a much neglected area of research that needs more investigation on the control and capacity element of food choice.

5.4 Individual capacity and the role of the intervention

Angela attended four weaning sessions at a SureStart children's centre. She lives with her partner and 6-month-old daughter. Angela is in the kitchen and her daughter is asleep in the pram. Angela has decided to take advantage of the "peace and quiet" to prepare some weaning foods; she has some butternut squash roasting and is stewing some apple. Angela got involved with the food initiative through the local children's centre. She explains how

she felt about weaning before the intervention, her experiences of the sessions and what effect it has had on her food choices;

I didn't have a clue, not a clue! No, I didn't have a clue what I was supposed to be giving her apart from basic things that we'd been told by the health visitor and things like that but nothing really specific. I didn't know anything about how to get her off her bottles, when to start weaning or anything. It's like my mum was saying, when I was a kid they didn't have anything like this. She said when I was a baby they recommended weaning from four months but now they've put it up to six months. What confused me was before I went to the sessions I'd been into ASDA and looking at the jars of baby food it says from four months, but my health visitor said 'no, from six months' and that's just Government guidelines isn't it? The Government is saying don't wean before six months but they are allowing companies to sell food for from four months. With your health visitor they say 'oh just try him with this, oh just try him with that'. I didn't know how to cook an apple. I've never cooked apples. I've always just ate them as they are. I've never had to peel and core an apple for a baby. Just things like that, I didn't have a clue. So I was at the Children's Centre putting my name down for baby massage and the women there asked me how old [daughter] was. She was about three months at the time and she said, "do you fancy doing anything to do with weaning"? I said yes I really

fancy doing something on weaning because I know nothing about it and that's how I came onto the "Cradle to Table" course. And it was a real surprise, I mean your health visitor tells you a bit but not as much as what [Community Food Worker, CFW] told us, she gave us a big list of what she can have at a certain age. They say like six months they can have certain things, and seven months they can have certain things as they get bigger but I didn't know any of that. To be honest I went thinking that it was lessons sat down pen and paper, but it was a big surprise and it was a nice surprise that it was hands-on as well. We cooked on all four of the sessions doing all different things. One of them the health visitor talked about weaning and another session we talked about the 5-a-day, salt content, when children get older and their lunch boxes, so we did cover quite a bit really but the set-up of it made you feel that you were getting information but you were not bombarded. There was a bit of paper work which stays in your head but the actual hands-on sticks in your memory more than if you have been sat down for an hour, someone reciting things at you. I think if you have actually done it, it stays fresh in your memory. I thought the way that it wasn't just classroom style, just sat there, information, information, information, but going in the kitchen and then actually doing it, I thought that was amazing. That was the best thing about it for me, the hands-on because I wasn't expecting it to be like that. I was

expecting to go into a classroom and it be ‘this food has got such in it’ and I expected it to be all sat at a desk writing, writing, writing. The first week when we went she said we are going in the kitchen, I loved it. Personally I’m not a very good cook, but with having [daughter], she started being weaned at five and a half months, and I wanted her to have the best food and I wanted to know about food. So that’s why I thought it would be a good idea to go and to learn how to cook, and learn all about the different things that would be helpful and all the nutritional things and values of salt, because there are loads of things I didn’t understand about it. It’s just mainly because I want [daughter] to eat really well. So it was good to be able to try some recipes with someone there. You would go in have a little chat, sit down, have an information time and a chat drawing on our own experiences with our foods and things, went to the kitchen and cooked a recipe in which we all participated, and then we got our children and then sat around the table and ate and everyone tried the food. You found that a lot of people, even adults, who said “I don’t eat cheese” because the recipe was there in front of them were encouraged to try new stuff themselves. [CFW] was just really approachable and easy going. You didn’t feel intimidated whereas sometimes you could feel intimidated, like you don’t know what to do with the butternut squash. Like I had never used couscous before, made a curry or put courgette in things,

just stuff I wouldn't really have bought or tried cooking with. [CFW] was really nice and there were different people at the sessions, we were all sort of from different backgrounds and she just made everyone feel the same, nice and relaxed and it was really enjoyable. You could ask anything even little questions you know that you were just really unsure about, no matter how stupid they were. It is totally different because with your health visitor you can ask them questions and the health visitor will say, 'oh, Government guidelines is six months' but with [CFW] she gave me the actual recipes. It was more in depth information from the sessions definitely. Even something like the nutritional information, she gave us a card saying how much salt is in things, whether it's too much, too little or just right. Even now when I go shopping I find myself looking how much salt is in and I've never done that before. Never been interested, just thought if I like it I like it and I eat it. Even though the baby is not eating it all yet, it's for me and her dad, I still look at the ingredients listed and the nutritional information. It's just habit now, it's weird like. Now I know that if it's got too much salt in, then I pick something different, I pick an alternative. I think it is hard work to have the perfect diet, it's so hard not to just fall into that trap where they just eat rubbish all the time, but I don't think it's hard to alter slightly, just change things a little bit, like don't eat as many crisps, don't eat as many chocolates, have some grapes instead.

Don't have butter on your toast have a low fat spread. It has changed me and even though my fella didn't go it's changed him as well. It's given me confidence, it's not scary any more. I was quite scared because I didn't know what went in what. Obviously, my daughter is eating better, she had pureed apricot this morning. That was something that I learnt because I wouldn't have even thought of boiling up dried apricots. They said put a hundred grams of dried apricots and a bit of water, boil them up and then soften them and then puree them and that's what I did and she loved it. I put it with baby rice because it was a bit strong, she loved it and it helped her go to the loo because she was a bit constipated. It was great. And I've got loads of it left. I've got cubes of everything coming out of my ears, most of it orange, butternut squash, carrot, sweet potato. Luckily, I've labelled everything or I'd never know what I'm giving her! It has really influenced me it has just giving us the right knowledge and the right sort of things to look out for in children's meals and what kinds of things we can cook for them and very easily cook for them with things that we've got around and about, and it's better food. I feel like I'm a better mum now, I feel like she's getting what she needs and I don't have to rely on packet stuff and jars.

Clients, by virtue of attending the sessions provided by the initiative are demonstrating a certain level of capacity and problem solving capability

already. Clients indicated that the main reason for attending the sessions was due to a real desire to give their children “the best start in life”. Clients wanted the most appropriate and accurate information, to improve cooking skills and have the confidence to know what they were doing was right that is, verification of their actions.

As described in the fictional example from Angela, the outcomes seen in clients, as a direct result of attending the sessions provided by the initiative, were reported as an improvement in nutritional knowledge, cooking skills and cooking confidence. Moreover, the findings indicate an improvement in self-efficacy, control and thus individual capacity, leading to changes toward healthy dietary behaviours. Improving the capacity of individuals, enabled them to develop the “tools” necessary to problem-solve themselves and to overcome barriers, barriers that appear bigger/more influential for those with a sense of reduced capacity.

The approach taken by the Healthy Living Centre Government initiative aimed to work within a community development (CD) framework to elicit CD outcomes, albeit delivered inside confines of scheme funding and delivery objectives. As previously discussed, CD models aim to improve the competence of individuals and the conditions necessary to make positive changes leading to improved health outcomes (Freudenberg et al., 1994).

Brazilian educationalist Paulo Freire produced the CD model to develop literacy levels and skills of politically oppressed groups (see Chapter two). In

doing so, Freire afforded them better control over their situation and made them better equipped to meet their needs. Freire taught with an in-depth understanding of his subject's world (Kane, 2001). The purpose, to educate within the context of the lives of individuals so as "to create the conditions necessary for solving health and social problems" (Freudenberg et al., 1994, p. 295). In doing so it was intended that individuals would develop a "critical consciousness", to be able to communicate their experiences to others to better meet their needs and thus increase control over their environment (Kane, 2001).

In Brazil, Freire focused on the importance of context (an understanding of worlds) for education and the role of cultural workers to do this (Kane, 2001). Although this model is for use in literacy, these theories can be and have been synthesised for use in health promotion. In the current research mothers talked about the pivotal role of the community food worker (CFW), the appropriateness of the information, the way in which it was delivered and the characteristics of the community food worker. Having an understanding of food culture that is the social environment in which food is consumed, meant that mothers received the information in the way most appropriate for them, which proved most effective in eliciting change. Previous research supports the use of community workers for the development of CD outcomes, Kennedy (2006) looks at lay health workers in nutrition and reports on their role as cultural advocates with a credible message that not only applies to the population at hand but is delivered in the most appropriate way. The evaluation of a community cook scheme in Knowlsey, Liverpool,

demonstrated the pivotal role of the food worker for addressing cooking skills, access and confidence in addition to a healthy diet (Ellahi, 2010 featuring research by this author, Gregg, R). Research from Becker, Kovach and Grosneth (2004) also demonstrated the role of community workers for empowering pregnant women/mothers with young children and for influencing self-efficacy, empowerment, and social support networks in an American cohort. This element is discussed further in chapter seven in relation to social capacity.

Evidence from several sources in a review by Popay et al. (2007) demonstrated the effectiveness of CD interventions for community engagement and involvement, empowering communities “in the areas of capacity building, skills and knowledge development...for building a more united local ‘voice’, increasing tenant’s political efficacy” (p. 3) and social capital and social cohesion. Thus the National Institute for Health and Clinical Excellence (NICE) recommends the integration of CD principles into health promotion activities that address the wider determinants of health (NICE, 2008). Although not extensively researched, CD has received some attention in the field of nutrition in terms of improving the health behaviours of pregnant women and mothers of young children from low-income backgrounds (Becker, Kovach, & Gronseth, 2004), the importance of capacity building and community participation for improving family access to foods (Morón, 2006). Furthermore, CD programmes have been shown effective for providing a sustained intervention (Kelly & Caputo, 2006).

5.5 Conclusions

Dowler (2008) agrees with the findings of this research, that there is more to the complexity involved in food choice beyond that of education, income and skills. Defining the main influences on food choice is critical for the development and implementation of policy to address resultant health inequalities.

For clients and non-clients, individual capacity (self-efficacy and empowerment) has emerged from this research as the most important determinant of food choice. A factor which has meant participants either engage or not with healthier eating patterns. The ability to problem-solve is also shown as important for addressing a number of common barriers in this population that is, cost, food skills, cooking confidence, and food access.

With the knowledge that individual capacity has such a bearing on food choice, applying the theoretical perspective of community development (CD) to the data has enabled a deeper understanding of the complex and contending influences involved in food choice. Furthermore, this has provided an indication of a 'hierarchy of influences' for mothers of young children (Figure 4.4 in Chapter 4). This particular finding supports the use of CD principles in community food interventions for mothers of young children and, the re-examination of health policy in achieving its target of engagement in health in the UK.

The other key emergent themes discovered from the research were associated with the significance social networks and geographies. These themes are discussed in the following chapters with respect to how they relate to CD theory.

Chapter Six:

Mothers, Culture and Influential Others

6.0 Introduction

This chapter presents research outcomes on mothers, culture and social networks. Ethnographic fictions are used to represent the themes of gender social norms, the influence of the participant's mother and upbringing and the role of social networks such as family, friends and community group support. These themes are then discussed in relation to socialisation theory and social capital approaches (Bowen, 2009; Kay, 2006) as a means of community development.

6.1 Gender roles and food

Sue is in her early thirties and lives with her husband and two children, one aged eight and one aged eight months. Sue's house is on one of the housing estates in Skelmersdale and is fairly modern inside. She starts the interview by saying that she had bought her house from the council a few years ago and she was selling it for a good profit. She talks about her main food choice influences, her upbringing, her mother and her husband;

I generally get most everything from ASDA but I do a bit of shopping around, like I'll make a trip to the farm shop because

my husband likes the steak [laughs]. He's more of a chef than me, I do the cooking, the day-to-day sort of stuff and if he wants to try something new, he'll tend to cook that. He actually influences me quite a lot. My husband's from an Italian background you see, it's pasta, everything's pasta, like pasta dishes you wouldn't believe the size of them you know. We eat a lot of stuff with garlic and things in but I mean [youngest son] will sit there and eat a full bowl of pasta and garlic bread and things. But yeah, he gets sick of things quite quick so I have to change what we eat all the time. I'm forever in the kitchen, I'm either in the kitchen, out with the dogs, at work or with the boys, so busy house really. I think it's because I've been brought up that way, my mum came from the old school where you had fresh meats, fish and your vegetables, you always had breakfast, it was "you're not leaving for school unless you've eaten" kind of thing. We never really had any convenience food, well it wasn't really widely available back then, they weren't any McDonalds or anything like that, we always ate proper home cooked meals, never convenience food. I've never really had a diet of burgers and nuggets and stuff, we've always had proper home cooked meals every day, so that's how I do it as well. My mum's never bought ready meals so I've never bought them, and whereas I think if I was brought up on ready meals I would buy them. When we were kids, the money was really really tight so me mum had to be

really careful about what she cooked so we never had takeaways and we never had pizzas or ready meals because she used to cook everything and then make it last. For example, if she did a stew she could save some and then maybe make a pie a few days later and she'd freeze it, she was always inventive was my mum [laughs]. I learnt how to cook from her so it is important what my mum does. My dad cooks a bit as well, so I've learnt from my mum and dad how to cook everything from scratch. My mum makes a lot of homemade soup, she's got an allotment in Ashurst, she grows her own veg and potatoes, so she gives me some, you know beans, green beans. She puts it all in a big pan and she makes like a bean soup with pasta, like spaghetti, she makes a huge pan and, [eldest son] just loves it, he'll eat a big massive dish full you know. My mum's here all the time, she even helps me with the butternut squash, she usually peels it, it's hard to peel and I was "mum how do you peel this" and she went "it's hard I know", so she peels it and puts it all in the freezer and then I get two or three cubes out when I'm making [youngest sons] dinner. It's just the way my mum's taught me how to do it. I've never learnt any other way so I've just done it that way. I won't use salt in nothing I'll just leave it out. If I'm doing mashed potato I'll do it with real potatoes I won't use the instant stuff, I've never been brought up on instant mash. My mum is very health orientated, she's always looking at the

labels, always looking at things, always on a diet and healthy, always going to keep-fit and running so I got it off her. Growing up my mum never let me have sweets and things like that so I guess that's why I'm like that. (Non-client)

Previously, we saw Kathryn talk about the number of restrictions on her children's diets and how she felt bombarded with information and very unsure of the "right" thing to do (see section 5.2). Here Kathryn demonstrates how her upbringing has influenced these decisions;

We stayed out the kitchen, I was the youngest of four girls you see. Growing up everything was frozen food, especially when we were younger, when we were older it got a bit better but, it was just sugar, cakes, biscuits and juice and that was it. You know I look back and like as soon as we went into the house it was a biscuit and juice and that was how we all grew up. All my friends were the same and my family was the same - that was the way it was. People weren't really saying "you must have this" and "you must watch what you eat" and I think sometimes that's why I think, well I don't want to completely take that away from my kids, I don't want to say to them "oh you got to be all super healthy". I know people who do go to the other extreme and I think well, yeah, ok that might be good but I also think I don't want to take their childhood away. And then I think well maybe I shouldn't give them little treats but then, when you remember being a kid, you remember stuff like

that. We were given sugar butties when we were kids, we'd got to Nans and the bread would be in the sugar bowl, because that's their generation, so we'd go to my Nans and we'd be like "Nan, can we have a sugar butty" because we knew she'd let us have one, and to think if you gave your kids that now, you wouldn't would you, you'd be there going "brush your teeth! (Non-client, aged thirty-one)

On the same subject, Shelly said;

It was my birthday yesterday, I was twenty-four. Twenty-four and I've got four kids. My mum and dad didn't change anything when I was young and I turned out pretty fine so I don't think it's going to be any different for my children. (Non-client)

Mothers from both client and non-client groups felt the responsibility to wean and feed the family as their sole responsibility. Partners/husbands did receive frequent mention with regard to cooking for enjoyment, using specific cooking techniques such as barbequing or for making a particular speciality dish, statements such as "he makes a really good spaghetti bolognaise, so that's what he does". Previous research highlights the central role of women/mothers in all aspects of food provision that is, purchasing, preparing, serving etc. and that women solely bear this responsibility (Beardsworth et al., 2002).

In this study, mothers expressed their desire to feed and please the whole family. The need to prioritise the diets of partners and husbands is identified as a need based on social ideology rather than on biological requirement. This thinking was previously influenced by the manual employment of the lower classes and it is still more likely to be found in such groups (Fieldhouse, 1996). In addition, mothers from lower class groups are more likely to prioritise the likes and dislikes of the family over their health needs (Hupkens, Knibbe, & Dropp, 2000). This conflict lead to a dichotomy of feelings where participant mothers felt a real desire to feed the family healthy meals balanced with a desire to please the family with what they were providing. The verification received in return from the family made mothers feel validated in their ability to nurture and thus influences food choice decisions.

The cooking of separate meals for different family members was not a finding taken from this analysis. Mothers (clients and non-clients) indicated a level of pride in that they were integrating their child's tastes and choices with that of their own. However, in prioritising the likes and dislikes of partners and children mothers were minimising the need to do this. Anving and Seilerberg (2010) observed this phenomenon in their investigation of parent and child diets in Sweden. The authors observed that lower class parents in particular were more concerned with socialising their child's preferences into their own. Conversely, in the Swedish study, it was seen that middle-class parents, who appeared to have higher aspirations for their child's future, wanted to socialise their children into their culture and also exposed them to new and different tastes and to have an "open mind" regarding food. Investigations of class

differences in food consumption have concluded that the working classes particularly adhere to cultural traditions and norms while purchasing and eating novel foods are a characteristic of the higher classes indicating status and separateness (Anving & Sellerberg, 2010; Bugge & Almas, 2006; Warde, 1997).

Socialising children in to the “food ways” (culture and habits) of the family was seen as a strong influence on food choices for participants (see section 6.2). The mother and upbringing of the participant in turn, influenced this. The passing on of food purchasing/preparation/cooking practices from parent (mother) to child, generation after generation appear particularly relevant with a demonstrable three-generation influence that flows from mother to daughter to grandchild (as seen in the fictional account from Sue, section 5.2). The strength of this influence is attributed to the complex socialising role of food outside of the basic provision of adequate nutrition. According to Anving and Sellerberg (2010) “meals are intense moments in the reiteration of family values and...of family food culture” (p. 205). It would appear that, among the participants in this research, parents used mealtimes as a teaching opportunity to demonstrate culturally appropriate values and behaviours. Indeed, it has been demonstrated in this research that eating preferences are largely determined by what is familiar to us (Savage, Orlet-Fisher, & Birch, 2007).

As shown in the examples earlier in the chapter from Sue, Kathryn and Shelly, socialisation (the passing on of cultural habits through the generations) can be

as much constricting as it is liberating in terms of food choice. As we see from Sue, an upbringing that demonstrates food confidence and promotes “open-mindedness” of foods is empowering and evokes feelings of individual capacity. Comparing this with Kathryn, who was constrained by her experiences of her mother and the food given to her as a child, this left her in a dichotomy between the pull of socialisation and the restriction of what is “normal” and, what is perceived, the healthy choice.

Although gender roles have evolved, women and working mothers are now common place, cultural norms are still apparent and are most pronounced in the low income/more deprived groups (Anving & Sallerberg, 2010). This appears to create a double burden for mothers who are still required to adhere to gender social norms. In seminal research, Charles and Kerr (1988) document that employment did not affect whether partners cooked more in the home, both part-time and full-time employed women did not receive anymore help from their partners. Slightly more recently, Warde and Hetherington (1994) found female employment was the greatest factor for men preparing family meals, but that this is still influenced by class in that employment rates are found to be lower for working class women. Research that is more recent is required in this area of changing gender food roles.

Through the food insights revealed from mothers in Skelmersdale it has been possible to piece together their ambitions, perspectives and priorities with regard to feeding their young children and families. This has previously been seen in the work of Dunlop (2008) who, in her exploration of Chinese cooking,

comments “I have discovered more about China in general through my food explorations than I ever did when I was interested explicitly in social or political issues”. Although far removed geographically from China, the empirical evidence gathered from the mothers in Skelmersdale indicates the importance of gender social structure and socialisation in food choice decisions.

6.2 Social networks for social capital

Emmy is a high school teacher and moved to Skelmersdale because of the lower than average house prices there. She comments;

My husband and I are both from Altrincham, and we'd just lived abroad for a year and coming back we wanted somewhere with land because we'd not had any, we'd lived in a flat in very built up area. It was so busy and we just wanted somewhere to grow vegetables and have our own piece of land rather than having someone living next door or living on a housing estate. We didn't want to be overlooked by other people, we just wanted it to be quieter. You can't get anywhere like this house in Altrincham you have to move further out and you are talking triple the price. So we came this way.

Emmy's child was three months when she attended the community food initiative sessions. She talks about her reasons for attending;

Originally it was to learn about weaning but I'm a teacher with a university degree so it's probably not targeted at me. I'm not daft and a lot of the stuff I found I already knew. I realised a lot of why I went was so that I'd meet other people in the area. I didn't know anybody around here as such because I've only lived here two years. Before I had the baby I was going to and from work in Altrincham so I really didn't have anything to do with Skelmersdale or the community. So the sessions were really good for that and now I've got a few friends from it. When I go to the town centre up there I just think 'oh, its horrible!' and I thought there was going to be loads of young mums there and there wasn't. There were many similar people to myself there and I really enjoyed it from that point of view. It became a real social event, I would meet up with other mums and we would walk to the sessions, we've even started going to baby massage together and we've put our names down for some other things at the Children's Centre. Even on the first session everyone was really friendly, you'd go in and everyone says 'hiya, do you want a cup of tea'. We all still keep in touch and we go round to each other's for a cuppa and that. It gets us out the house [laughs]! I did think it was going to be a lot of young mums and there were people there that had never cooked before and were saying 'is this how you do it, is this how you make a sauce' and I thought well that's fantastic for them. When you've just become a mum, at first you don't

know anything, I still don't know anything, but you need other people around that you can say to them 'oh God, I don't know what I'm doing with this' not necessarily your own mum but somebody in the same situation and it's really beneficial I think, it's really important to have it. I think without that [becoming a parent] would be quite depressing in a way. We've been on two baby massage courses even though they were the same and we're all going to sign up for the food hygiene qualification at the centre, it was just nice sitting there and chatting when your baby is there and enjoying yourself.

The account given by Emmy demonstrates a further dimension in the role of a community initiative. Emmy, a well-educated professional, was able to reflect on her experiences with the initiative and deduce that the most important outcome for her, being new to the area and the "community", was meeting people in a similar situation as herself and having the opportunity to talk to people and exchange experiences. For Emmy, the anxiety of becoming a parent for the first time was diminished and, in her own words, was made less "depressing" by having a network of friends to socialise with and learn from. The development of relationships between like-minded people happens as a product of homophily. Bottero and Prandy (2003) and Bordieu (1984) support this finding: in this study, connections were made between people in a similar situation, whether of social class (as is alluded to with Emmy's reference to young mothers), or of being a new mother. Emmy developed a network of

friends who continued to meet up and further their involvement in other group activities (on baby massage and food hygiene sessions).

Building a social network is the first step in accumulating social capital (definitions provided in Box 6.1). Social networks can be formed either between individuals or organisations which develop “strong ties and a working relationship based on shared values, visions and goals...” (Bowen, 2009, p. 246). According to Bowen (2009) individuals with strong social connections have access to more resources, more support and tend to be more “hired, housed and healthy”. Social capital is developed through social networks, which produces a stock of resources over time for individuals (or groups) sharing the network, resources that include the empowerment of its members and reducing social exclusion (Bowen, 2009).

Kay (2006), explains the process of social capital:

...one person makes friendly contact with another, which leads to mutual trust developing between them, resulting, in turn, in mutual understanding and some reciprocal actions and that may lead in to further social contacts and so on. (Kay, 2006, p. 146)

Through social networks participants were able to develop a feeling of community in the sense of “a web of relationships defined by a significant level of mutual care and commitment” (NEF, 2000 cited in Kay, 2006).

Box 6.1 Definitions of social capital

“Social capital consists of the resources within communities which are created through the presence of high levels of:

- trust,
- reciprocity and mutuality,
- shared norms of behaviour,
- shared commitment and belonging,
- both formal and informal social networks, and
- effective information channels,

which may be used productively by individuals and groups to facilitate actions to benefit individuals, groups and the community more generally” (Kay, 2006, p. 163)

“The resources (material, social and in-kind) available to individuals through social behaviours and community networks” (Dowler, 2008, p. 291).

“The shared values and attitudes that influence the way people interact with one another, as well as the structures and organisations (both formal and informal) that enable productive working relationships” (Bowen, 2009, p. 246)

This social capital is a means by which community interventions can produce community development (CD) outcomes, such as bringing individuals together and reducing social isolation. Previous reports on social capital tell us it has two separate dimensions; “bonding” social capital and “bridging” social capital. The former refers to relationships formed which bind like-minded individuals together (horizontal linkages) and the latter which form

relationships with outsider individuals, groups and organisations (vertical linkages). It is the vertical linkages that are important for the community development process, these are connections that are made with those who are more privileged, enjoy greater social status, wealth and power (Bowen, 2009; Kay, 2006). The account by Emmy demonstrates the beneficial linkages that could be made and CD outcomes that were developed because of participation in the initiative that is a support network that provided the opportunity to talk to people and exchange experiences. However, it is unknown whether they were of a horizontal or vertical nature; this is something that requires further investigation in regards to PHN interventions.

The role of the CFW, as discussed in the previous chapter, plays a pivotal role in the development of social networks and thus social capital in this intervention context. Examples of comments made about the CFWs were, “they are just like one of us”, “I could ask her anything no matter how stupid it sounds”, “she told us stuff in a way that I could understand and that I could actually use” demonstrate a level of trust and mutuality, shared norms of behaviour and appropriateness of information. As previously explored, the CFW, as a cultural broker sharing common values and beliefs, can effectively convey information when the “source and receiver are homophilious” (e.g. similar in their background and experiences) (Kennedy, 2006). Conversely, when individuals differ considerably (heterophilious) and messages are inconsistent with social norms, thus conveying information is not as natural or effective (Kennedy, 2006).

For clients, forging close social networks and the use of CFWs would appear to have an empowering influence on food choice. Mothers developed trusting relationships in a secure environment and could access socially appropriate information and develop a network of support. An increased sense of support and “community” appeared to bring a greater degree of control to food choice decisions (as demonstrated in the story from Angela, see section 5.4). Where mothers were supported they felt less constrained by outer structural influences. We have seen that socialisation can be as constricting as liberating, for example, non-client Kathryn, felt high levels of anxiety resulting from the constraints of her upbringing and social norms, and felt she did not have the support to know she was making the “right” decisions (see section 6.1). Thus, social capital as a result of social networks and CD approaches could improve the capacity of mothers to make the healthy choice an easier choice to make.

Donna lives in the “new” Skelmersdale area, on one of the estates in Digmoor. Donna is approaching her 21st birthday and lives with her partner. She is not working, has a two year old son and has just found out she is pregnant with a second, “it wasn’t planned” she says. They live in a basic split-level flat and she is reliant on Government benefits for income. In her living room, the TV is on and her son is playing on the floor. Donna attended the sessions over a year ago, she tells me how she got involved with the food initiative and why she attended the sessions;

I met [food worker] at a session for young mums when I was pregnant and I told her how much I liked cooking so she rang

me up when these sessions were coming up to see if I wanted to do them. It's not that I wanted to go to improve my cooking skills so much, I'm quite a good cook, I even started doing a catering course at college before I got pregnant. It's cos I wanted to meet new people and get me out the house. We did cook some soups that I hadn't done before but that wasn't the real reason why I wanted to go. I did meet new people but I didn't stay in touch with anyone. I wanted to eat healthier too and I tried, I did change, I tried cooking the soups and eating healthier, and the soup and that was filling me up but then I started snacking again. I made the curry, which my boyfriend loved, and I cooked some of the other stuff like the roast veg with the butternut squash, but I just went back to my old self again. I don't know why, it's not because of him [son] he's not fussy at all, he'll eat anything really. At first, I was really enthusiastic and I cooked all the recipes but it just started to trail off. I'm just really busy, he [son] can be really hard work. It's just having the time to eat, with him [son], he's on the go all the time, so I just tend to eat crap. I just don't really like trying new things in case it goes wrong, I like to stick with what I know...It's hard [parenting], I tidy up the house and then he just messes it so I don't bother. I've tried leaving him in the crèche but he doesn't like being away from me. That's like my own fault because he's with me all the time, I should take him to the groups. I used to go all the time but I don't find the time

and now and he won't go in the crèche because he wants to be with me. He's alright with my boyfriend, but that's not his dad and me mum and dad live in France. Everyone says 'why are you here in Skelmersdale on your own'? I say 'I don't know, I got shoved here'. [A dog is barking] That dog's doing my head in, he's ate all the carpet and all the floor, it's only five months old [pause]. Do you think they'll let me do the sessions now I'm pregnant again? (Client)

Following the interview evidence of the wider socio-cultural influences facing Donna was considered, as follows;

RG Memo 13/9/07: Donna is reliant on Government benefits, is not yet 21, lives with her partner who without prompting openly tells me is not the father of her first child. She does not have any family support network and mentions being "shoved" to Skelmersdale. For Donna, healthy eating behaviours and her enthusiasm were maintained during her involvement with the project but not after. She sees herself as a "confident cook" but is without the capacity in terms of support to put these skills into action. She is almost 21 years old with a young child and pregnant with a second, her support network is small. She finds keeping up with the housework pointless and looking after her young child hectic. Donna does not have access to a car and cannot drive, has limited access to food and is restricted to one supermarket she finds expensive.

Donna says on a number of occasions that she wanted to attend the food project to meet people and get out of the house suggesting she is fairly isolated.

Consistent with Emmy, Donna attended the sessions primarily because she was new to the area and wanted to meet new people, which came secondary to developing her cooking skills and knowledge of weaning. She too was empowered enough by participating to put in to practice some of her new experiences which, she attributed particularly to the (previously discussed attributes) of the CFW. However, what is not consistent with that of aforementioned client participants was that she did not manage to maintain any of the dietary changes she had implemented or any of the social relationships she forged during the sessions. Donna's story suggests she is isolated within her social confines, she mentions (on several occasions) that she wanted to meet new people, that her parents live abroad and felt she had little connection with the area.

According to social capital theory, the more supported people are the more control they have and the less constrained they feel by the wider environment (Kay, 2006). This did not seem to be the case for Donna. It is possible that other stronger social networks were formed in the group that attended her sessions, if this is the case, this could have meant further isolation for Donna (Bowen, 2009). It is of note here that not everyone experiences the same success from attending the intervention, and that for some, engaging with health can be more challenging.

It would appear that Donna has a small social network and was not supported enough, post-intervention, to maintain any of the positive changes she made with regard to diet. As she articulated “I just went back to my old self again”, where she is referring to the practices and behaviours she had developed over a lifetime which overcame any new behaviour. Without a support network and further input from the initiative she did not feel she had the capacity to overcome the external barriers presented to her, for example Donna felt that the limited amount of time, money and support from her parents were her main influences on food choice.

Socialisation and social networks appears high in the hierarchy of influence on food choice and although the intervention had real impact for some, other participants felt that the level of contact (one 2 hour session per week for four weeks) was not enough to overcome what food habits were already entrenched or address wider social pressures. Previous reviews on the effectiveness of dietary change interventions demonstrate that interventions that comprise of ten weekly, two hour sessions provide better opportunity for “personal contact with educators, social support, goal setting, group work and activities involving food” (Wrieden et al., 2007, p. 205). When designing effective interventions, the use of a CD approach through the development of social capital and length of involvement/follow-up needs careful consideration.

6.3 Conclusions

Lang and Caraher (1998) presented evidence that supports the high level of food involvement by women, calling them “mediators in food culture”. Women have to balance social norms, historical influence, family preferences, and concerns on family health, not to mention food access, affordability, acceptable quality and time pressures (these will be the focus of the following chapter).

Dowler (2008) argued that influences such as knowledge, educational level, and household income are some of the lesser influences that mask a more complex picture of food choice. This research shows that social networks, community membership and social capital are just as relevant in the choices we make, although this aspect has previously received little attention in nutrition (Dowler, 2008). If strategies were to acknowledge and build on the significance of the socio-cultural role of food and have an understanding of the wider gender implications such as the role women have on food choice, this should mean that white paper priorities and strategies for dietary change interventions are more informed and more effective.

Stafford et al. (2007, p. 1893) described social capital as “a moderator and a variable lying on the pathway linking local socioeconomic characteristics to health”, thus it is not the only predictor of health. Forces such as the built environment and public services have also been linked to diet-related inequalities.

Chapter Seven:

Diet and Health Inequality as Determined by the Geography of an Area

7.0 Introduction

This final chapter considers one of the most prominent emerging themes from the Skelmersdale research. It focuses on the importance of the geographical area of Skelmersdale and the living surroundings of client and non-client participants for influencing food choice. The themes presented as ethnographic fictions display the experience of living in Skelmersdale, the physical issues of access to food such as town planning, car ownership and, presence of superstores. The complexity of these themes is examined in relation to existing theory on “place” and how participants operate within their locality and the influence on food choice. The application of these findings is then discussed with regard to wider structural and environmental changes.

7.1 The built environment

Whilst working and carrying out research in Skelmersdale it was observed that the complicated road networks, numerous housing estates and general physical structure (as a result of town planning) such as a lack of pavements, made travelling around the area fairly challenging. Therefore, participants

were asked about the “unique” physical structure of the area and if it was something that residents had an awareness of and if it was as problematic for them as it was for someone new to the area. This was mentioned to Kate, who had always lived in the area and was now married with a daughter;

It's a nightmare for paths, absolutely horrific! The Skelm [Skelmersdale] vision from when it was built in the sixties was to build the walkways to keep people away from the roads, because they had this utopian vision of people walking and subways being safe and all that, but then you want to walk by the road because usually it's the most direct route or they're the safest because there's more people around. All the hidden little paths and everything, they thought it was safer for kids playing, but they didn't realise the kids would have to walk in the road to get anywhere they wanted to go! By the Concourse [local shopping centre] is particularly bad, and to ASDA there's one path and there is that subway where people keep getting mugged in which people aren't going to walk though are they? To get to ASDA, unless you've got a car, you have to get a taxi or take the bus you can't really walk from here. It's not too bad here where I live in Old Skelm but I used to live in the estate and my best friend still lives up there. To walk to her house, if I wanted to walk the short way, I have to push the pram on the road. I'm used to it but my husband's not from round here and he couldn't get over the complete death trap that it was when you've got to walk anywhere. I get a bit

baffled by it, I was driving along yesterday and there was an old man just walking along the side of the road quite happily and it's a main road! You just think there should be a pavement there. I've lived here all my life, I've lived in New Skelm and I've lived round here. When I go to Tanhouse I can get completely lost, yet put me in Liverpool city centre and I know my way round. Up there (New Skelm), because it all looks the same you think, where the hell am I! [RG: "even for someone who's lived here their whole lives..."] Um, I know people who live in Tanhouse and they don't know their way round here (Old Skelm) and it's really weird for such a small town but people tend to stick where they are and not venture out. The Concourse [local shopping centre] is probably the only common ground and if you're from Old Skelm you stay there and if you're from New Skelm...It's really weird. (Non-client, 28, mother of one)

This account by Kate particularly highlights the issue of unseen boundaries and a lack of interaction between people from different areas of Skelmersdale. Tina lives in Old Skelmersdale with her mum and 6 month old daughter, she describes the distinction between the two areas of Skelmersdale;

This is Old Skelm, these houses were here when the mines were here, this was established before Tanhouse and Digmore areas so I wouldn't walk round up there, I've never

any need to, I don't walk really, I take the car, there's no reason for me to be up there.

Sandy, as previously described, is fairly new to the area, and she talked about her experiences of driving in the area,

It's odd, if you haven't lived here for a long time, or even if you have, you don't know how to get anywhere. You have to imagine Skelmersdale like one big circle with lots of roundabouts in it, there's even a half-mile roundabout! Say, to walk to ASDA it will take me about 5 minutes but if I want to go in the car it would take me longer because I have to go all the way round the roundabouts to get to the other side of the road... to be honest I know how to get to the Concourse and ASDA and that's it basically, even though I drive it's one of them, I know just how to get to where I want to go.

Donna doesn't drive or have access to a car so has to rely on public transport to get to the shops, she talks about where she does her shopping,

Most of the time I go to ASDA and the concourse, that's all there is really, unless I go to Wigan but I don't want to cart everything on the bus just to go shopping, so ASDA is the only place. There is a shop up there [corner shop] but there's not very much in it, basically if you can't get it in ASDA, you can't have it.... once I've got the shopping I get a taxi back, which costs a bomb. I always have to pay a taxi when I've been

shopping, you can get the bus but you still have to walk from ASDA to the Concourse to catch it.

The accounts given here demonstrate the complexity of the issue of mobility in Skelmersdale, participants talked about their feelings of personal safety relating to perceived high crime levels. The accounts from Kate, Sandy and Donna have highlighted the difficulties they experience travelling around the area, and how reliant they are on personal cars or public transport to access the food outlets.

The built environment as defined by Bernard et al. (2007) includes “buildings, transportation systems and open spaces... It also includes the characteristics of neighborhoods’ physical structure such as street connectivity, land use, sidewalk continuity, and aesthetic quality of the area” (p. 1844). Bernard et al. (2007) implicates a negative built environment in poor health due to increased mental stressors to do with housing conditions and neighborhood disorder, reduced options for outdoor activity, and reduced opportunities for social interactions such as in parks, interesting destinations to walk and physical safety. The built environment has previously been investigated in an American context, research found that complex street network patterns were counterproductive when encouraging people to walk more (Wells & Yang, 2008). Feelings of personal safety are the main concerns parents have when walking out with their children. Consequently, levels of outdoor activity and walking for exercise and fitness purposes are reduced in areas of perceived low personal safety, interesting though levels of walking are higher in deprived

areas out of necessity rather than choice (Ahlport, Linnan, Vaughn, Evenson, & Ward, 2008; Stafford et al., 2007). In this context, parents perceived level of neighbourhood safety has been associated with higher levels of childhood obesity. In a public health context, the findings of the Skelmersdale study are important due to the recognised benefits of physical activity on health and obesity prevention.

The data presented in the ethnographic fiction from Kate above, brought to light the issue of unseen boundaries for restricting movement within the area. Areas were defined as “Old Skelm” or “New Skelm”, with the new areas of the town being the result of redevelopment in the late 1970’s. Further investigation of development issues and mobility revealed that participants stayed within their area and knew their way around but that movement was restricted between the new town, a more deprived area and old town, containing the relatively affluent areas of Skelmersdale. Delimited movement such as this described by the Skelmersdale participants was identified on a small scale by Hackett et al. (2008) in nearby Liverpool suggesting that such boundaries were created due to the physical characteristics of the locally that is, busy roads, cul-de-sacs etc. These were used to provide secure/“safe” environments for children to play but which limited their activities. What was seen here was a clear representation that Skelmersdale residents would not consider movement out of very localised boundaries and as such would not use retail outlets in those areas. The Concourse shopping centre and ASDA supermarket, both in the centre of Skelmersdale were referred to as common ground. However, there were inconsistencies between the awareness of, and

access to, smaller independent shops such as the “shopping parade on Sandy Lane” (in the Old Skelm area), butchers and greengrocers. If residents are not aware of these outlets or if they are not readily accessible to them, this could have implications for food choice and consequently health. Although research has investigated social and physical environmental influences on health (discussed throughout this chapter) this research provides evidence of a need for further investigation into these unseen boundaries and any relationship to food choice and behaviour. For example, participants were not all aware of a local health food store, the “Sandy Lane” shopping parade or fruit and vegetable box schemes provided by the SCFI.

The unique road network and town planning of Skelmersdale may provide some explanation of the necessity of owning/using a car in this town and the distinction in food access between those that drive/have access to a car and those that do not. A reduction in the level of car ownership is naturally linked to income deprivation and other socio-economic variables such as employment, age, marital status and location. Research from Caraher, Dixon, Lang, and Carr-Hill, (1998) shows that those in the most deprived groups relied much more on public transport and walking than car for mobility (Caraher, Dixon, Lang, & Carr-Hill, 1998). In the current research car ownership and access to a car was an important indicator of easy access to a supermarket. In Tanhouse, Skelmersdale, 46% of households own no vehicle. Skelmersdale has the highest proportion of people owning no vehicle in West Lancashire (West Lancashire Borough Council, n.d.), meaning that access to employment and services is increasingly dependent on public transport,

nearby facilities and sustainable design. Participants with cars found that physical access to food outlets within Skelmersdale restricted food choice much less. These participants would shop in the area and in the surrounding areas in towns such as Ormskirk, Wigan and Liverpool. Clients and non-clients without a car who relied heavily on public transport, taxis or walking and were limited to the shops available in Skelmersdale. Bodor et al. (2007) report a strong relationship between mode of transport and healthfulness of the diet, they demonstrated that car ownership was significantly linked to a healthier diet in terms of increased fruit and vegetable consumption in urban environments of the US.

Reporting on the built environment, American authors Bernard et al. (2007) propose that a neighbourhood's resources are not as equally relevant for everyone, but are more influential for those who are "place-bound". For example, individuals with reduced access to private transport, low income groups and those who spend more time in their locality such as "home makers", children and the elderly. Lang and Caraher (1998) have also made the connection between lower class status and low car ownership, but go further to characterise it as a "double jeopardy". The authors argue that women are more disadvantaged by the built environment than men due to the fact that women spend most of their time in the household and, that men have better access to cars and are more likely to possess a driving licence (Lang & Caraher, 1998). Lang and Caraher (1998) go on to say that for these reasons women have poor access to out-of-town shopping centres, have the added complication of carrying shopping and taking children with them on public

transport and are further compounded by low incomes which means they cannot commit to buying in bulk or in advance. When all of these barriers accumulate, also referred to as a “deprivation amplification”, they constrain food choice and further impact on diet-related health inequality (Beaulac, Kristjansson, & Cummins, 2009).

In an example from the UK, Dibsdall, Lambert, Bobbin and Frewer (2002) found that ownership of a car to be of little consequence when accessing a large supermarket in a large urban area. This was demonstrated by the fact that, of the 680 low-income men and women surveyed by the authors only 41% were car owners, but that 90% did their food shopping in a large supermarket and 79% shopped there once or more than once a week. In a study on food deserts, transport to supermarkets by car also showed a reduction over a twenty-three year period due to the development of supermarket stores being closer to residents in the city of Portsmouth (Clarke, Hallsworth, Jackson, Kervenoael, & Kirkup, 2006). The use of taxis has also received some attention as a “critical coping mechanism” for accessing food outlets but which better access to food outlets reduces the need for (Wrigley, Warm, & Margetts, 2003). The findings of a large multi-method investigation of an area deprivation, its environmental characteristics and the determinants of obesity in the UK, by Stafford et al. (2007) it was determined that close proximity to supermarkets, health-related facilities (pharmacies, opticians and dentists) and recreational facilities such as swimming pools and leisure facilities correlated with lower levels of obesity. Indeed, the authors concluded that the cumulative effect of proximity to a full range of shops and facilities

including locally owned green-grocers, restaurants, and convenience stores encourages walking for leisure. These factors all cumulate together and will have an effect on dietary patterns and obesity levels in this example from the UK.

In conclusion, built environment, town planning, road networks, presence of superstores and local food outlets influences food choice, as does car ownership (income), these all have consequences for the healthfulness of the diet. What the present research shows, particularly in light of what was discovered regarding unseen boundaries, (movement between areas in Skelmersdale and the ability to drive or walk in the area), is the additional issues of residents perceived access and awareness of outlets outside of these boundaries. It also brought to light the availability and acceptability of the choices available to them for example, will residents travel to other areas to access different food shops. This has shown to be important in previous research where the perception of a better selection and quality of fresh fruit and vegetables was associated with increased fruit and vegetable consumption in a review of research on food deserts in America (Beaulac, Kristjansson, & Cummins, 2009).

“People living in the same area share the same physical environment, and they are thus basically exposed to the same positive and negative resources” (Bernard et al., 2007, p. 1843). This quote taken from Bernard et al. (2007) coupled with the evidence presented from this research, supports the argument for upstream policies (policies that deal with the root causes “up-

stream”). Policies that increase development of the built environment to enable greater access to a range of large and small retail outlets and leisure facilities including access to open space in areas of low income and low car ownership such as Skelmersdale. If this were the case, some of the physical characteristics of the environment can be addressed to reduce its negative impact on diet and consequently, overall health of the individual.

7.2 ASDA Supermarket, Skelmersdale

What is noticeable when driving and working in the Skelmersdale area is that physical access to shops, either by walking or by car, and the availability to healthy foods may be a barrier to consuming a healthy diet. At the time of the research, the only supermarket in the town is ASDA, situated in the ward of Birchgreen. There is a town centre shopping mall (Concourse) which houses a frozen food store and a greengrocer. Within each housing estate there is a corner shop, Kate recalls, “they’re dire. You can get ciggies and sweets, you know all the essentials for life! Probably the only fresh stuff they’ve got is an onion and a bag of potatoes”.

Where it was felt that food choice was limited by access to just one supermarket in the area respondents reported feeling constrained and limited. These feelings appeared to increase the importance of other food choice influences such as acceptability (quality), affordability of ASDA, availability (range of choice in ASDA) relative to other supermarkets, local shops or

shopping centres. Participants discussed shopping around to cope with some of these issues. Sandy comments;

It does influence the way you eat because with only having one major supermarket and just a few little shops on the Coni you haven't got as much access to maybe other stuff that you would say if you lived in Southport, because you've got I don't know ten supermarkets in Southport and they all sell a little bit of something that's different you know. So yeah it does, it can restrict you.

Income data was not collected from participants. However, inference can be made from the profile details collected, and the impression gained by the researcher from this information suggests a low-income profile of participants. This headed a mix of discussion points that interlink with food choice to do with cost or perceived affordability. Donna's opinion was this;

They say it's everything all under one roof but they don't have everything and most the time it's too expensive. The people in Skelmersdale aren't really well off because most of them are on benefits, I know its nasty to say but, I know I'm on benefits, I hate it, and I hate being labelled like the young parent on income support you know. I can't wait to get a job so I can have a bit more money to spend.

Kathy and Jane make comment on the constraints of what is available in Skelmersdale and the issue of shopping around;

Kathy: [the quality in ASDA is] not particularly great really, the fruit and veg and things aren't really great. It's just going to ASDA is convenient, like I say if you had the time to go and buy from other places then you probably would, em, but there's not much you can do about it really [pause] It's just the situation we're in. (Client, 24, mother of 1)

Jane: if I'm on a tight budget I'll try and shop around, but once you've been here, been there, it's taken you all day and you've had to drag the kids round with you. I'm not sure how much you're saving...without a car the thought of getting to the concourse to get the shopping is too much, if it's a nice day I do try and make myself walk more but to get to the actual shops with the pram it's a good half hour walk. So I go to ASDA, it's alright, it's just the same things in there, they don't have a lot of variety but you know it's convenient and it's all in one place. (Client, 24, mother of 2)

The accounts given by participants about ASDA indicate their dependence on one supermarket that they feel can be limited and too expensive. Alternatively, they have the option of smaller retail outlets at the Concourse, which are again, limited in range and considered unaffordable except in the most desperate circumstances. Those who do not have access to personal transport feel their food choices are limited by what is available in Skelmersdale town.

Recent research from Lloyd et al. (2011) on the availability and affordability of healthy foods in the Ingol and Deepdale areas of Preston found that mothers on income support would have to spend a considerably higher proportion of their income to obtain a healthy diet from the food outlets in the area than average income earners (28-32% versus 10-12% respectively). Lloyd et al. (2011) conclude that any increase in food and fuel costs would affect residents on income support much more dramatically. Lloyd et al. (2011) also reported on the use of local, smaller shops to obtain a healthy diet. The authors found that local shop prices were competitive however, in order to obtain all the items required residents would have to visit up to five shops. Previous research has found that the price of corner/local shops is higher than supermarkets for items recommended for a healthy diet. Indeed, research conducted in the East Midlands by Donkin, Dowler, Stevenson and Turner (2000) found foodstuffs costing between 24-60% more, and that it was the staple foodstuffs that can cost as much as 60% more in smaller stores compared to supermarkets. The authors also found healthy options such as semi-skimmed milk and wholemeal products are often more expensive, if available at all (Donkin, Dowler, Stevenson, & Turner, 2000; Piachaud & Webb, 1996).

Although the research by Lloyd et al. (2011) is specific to one area and the population profile within that area, Preston in Central Lancashire and Skelmersdale in West Lancashire were both developed under the New Towns Act 1946 for overspill populations of large urban areas. As previously

discussed, Skelmersdale was one of the later redevelopments that took place under the Act, development which has suffered due to the recession of the late 80's and early 90's and consequently has resulted in a lack of transport links and planned regeneration (refer to section 3.2.1).

Skelmersdale and areas such as those described under the New Towns Act have previously been defined as “food deserts”, a term that was made popular in Government policy on social exclusion but which has received much research attention due to the increased incidence of nutrition related illness (Acheson, 1998; DoH, 1999b; for policy context see Wrigley, Warm, & Margetts, 2003). Food deserts have been defined as;

...areas of cities where cheap, nutritious food is virtually unobtainable. Car-less residents, unable to reach out-of-town supermarkets, depend on the corner shop where prices are high, products are processed and fresh fruit and vegetables are poor or non-existent. (Whitehead, 1998, p. 189 cited in Wrigley, Warm, & Margetts, 2003, p. 153)

Proximity to, and type of food outlet has been associated with healthfulness of the diet, and the increasing cost of a healthy diet (Caraher, Dixon, Lang, & Carr-Hill, 1998; Darmon & Drewnowski, 2008; Rose & Richards, 2004; Stafford et al., 2007). In a review of the literature on reduced access to the supermarket either by proximity or car ownership, it was found that fruit and vegetable consumption was compromised and, that the quality of pregnant women's diets was negatively affected (Rose & Richards, 2007). On the other

hand, easy access to supermarkets was associated with a higher intake of fish, fruit and vegetables, even within low-income populations (Stafford, 2007). Conversely, a higher presence of fast food outlets is seen in more deprived areas, which proximity and ease of access to has been associated with higher obesity rates (Macdonald, Cummins, & Macintyre, 2007; Stafford et al., 2007). However, it is important to recognise that, although it is agreed that neighbourhood structures have a strong influence over residents behaviours, these structures are reinforced through the behaviours of residents in the use of business (e.g. a fast food restaurant) in that locality (Bernard et al., 2007).

Skelmersdale shares characteristics with Seacroft and surrounding estates within the Leeds area. Seacroft is described by the authors;

Indices of deprivation place Seacroft in the top 5% most deprived wards in England...it is essentially a low-income, compoundly deprived, white (ethnically less diverse than the city as a whole) area. By the late 1990s it was regarded as emblematic of those areas of the city that had failed to share in the significant economic revitalization...which had left Seacroft...exposed to increasingly visible affluence in other parts of the city and surrounding areas. (Wrigley, Warm, & Margetts, 2003, p. 155)

This area was the focus of pre and post research intervention assessing the impact of the development of a new “state-of-the-art retail hypermarket” (Tesco) on the dietary habits of individuals in these most deprived areas. The

research demonstrated a positive impact particularly in terms of fruit and vegetable consumption. A review of food access research from the USA shows that access to large supermarkets has been associated with improved access to and consumption of fruit and vegetables, this correlation is particularly strong for low-income households. Access has also been associated with lower fat intake and the relative availability of low fat and high fibre foods. Healthfulness of the diet also increases with the presence of every additional supermarket store showing a positive impact of the element of competition between stores (Larson, Story, & Nelson, 2009; Morland, Wing, Roux, & Poole, 2002). In addition, research has found that residence in the most deprived post codes in the UK was independently linked to a reduced quantity of fruit and vegetables (Shohaimi et al., 2004).

As previously demonstrated, mobility and mode of transport in and around Skelmersdale can be inhibited by the built environment. However, those who were owners/drivers of a personal car overcame this physical influence. What can be concluded from the investigation of participant's lifestyles is the association between income deprivation, lack of car ownership and reduced mobility. Caraher, Dixon, Lang and Carr-Hill (1998) found that low-income families were less likely to own a car and demonstrated a significant link between mode of transport and income over all three means of transport that is, walking, bus and car. These authors also concluded a distinct link between income and healthy food choices. In the present research, the financial cost of a healthy diet was not shown to be one of the most important influences on food choice, as such participants placed cost further down the hierarchy of

influence (see Figure 4.4). In the Preston example however (Lloyd et al., 2011), the lower the income was the more the price of food was found to be an important factor. Although cost was not the most important factor here, it was still a consideration for both clients and non-clients alike.

Lloyd et al. (2011) demonstrated that relative cost (affordability) can be a barrier to a healthy diet. People of a low income spend a higher proportion on food shopping despite actually spending on average less on food (Dowler & Calvert, 1995). Wider research has also investigated the cost of what healthcare providers constitute a “healthy” diet. Research has shown that healthy foods are more expensive and less available in the more deprived areas (Mooney, 1990). Research has also shown that high-energy dense diets are associated with lower cost. Per calories meat, fish, fruit and vegetables are more expensive than foods with added sugars and added fats, and that supermarket promotions and buying incentives are focused on energy dense foods (Darmon & Drewnowski, 2008). Therefore, it follows that the cost and affordability aspect of diet inequalities cannot be underestimated, even though it was not one of the most prominent themes to appear from the analysis.

The “everything under one roof” concept was explored by Pettinger, Holdsworth and Gerber (2007), who reported on the use of supermarkets compared with small local shops such as butchers, bakers and markets between central England and southern France. They found the availability and quality of fresh vegetables was comparable yet they report significant

differences between the types of shops used between these two countries. The authors explain this difference is due to the cultural habits between the two countries, with the French tendency for small specialist shops and the English emphasis on convenience and time saving. However, the authors did find that the higher quality of fresh fruit in France did not compare with the lesser quality of those in England. This was the observation made in the present research, that the smaller retail outlets were expensive and of particularly poor quality and range.

Participants without access to a personal car felt the limitation of only one supermarket in Skelmersdale was restrictive and constraining. Participants felt that they had little choice but to shop there even when cost and quality were not to their liking. The literature strongly suggests that the presence of large supermarkets provides benefits in terms of better, easier access to “healthy” food. The dominance of one supermarket both economically and culturally has received criticism, and they have been blamed for “all that is wrong with the food system” (Reisig & Hobbiss, 2000). However, due to the benefits discussed that is, range, cost, easy access, supermarkets are well placed to address the issue of “food deserts”, as such the benefits of partnership working between the public health and private sectors such as retailers in the UK need to be explored (Reisig & Hobbiss, 2000).

7.3 Individual capacity and geographies

After discovering much regarding the barriers to food choice within Skelmersdale, how these factors influence eating behaviours and impact on the health of a community is of interest. There were two quite distinct responses from participants, those who felt they had many food options and those that did not;

Kate: Not at all for me, I get what I need in ASDA and the Concourse, and because I drive and I'll go out to Ormskirk and Wigan, I tend to shop around a bit...cost is not so important to me, of course it's an issue, everybody has to think about cost but it's more important to get what we need and think about that afterwards! We've also been growing our own in the back garden. We've only got a little patch but we grow, tomatoes, lettuces, cucumbers, peppers, sprouts, and a few other things.
(non-client)

Emily came into the community initiative office looking for volunteering work, Emily is a single parent of two, she is dependent on Government benefits, has just moved to Skelmersdale and is living in temporary shared housing. Her perspective on food choice influences appeared very empowered;

I walk everywhere. I walk 'em to school, I walked here, I walk to the shops, we're always out walking...I can do anything I put my mind to really. I've got everything that I need, I mean I've only got two pans but I can wash it and start again if I

need to do something else...when I go shopping I always go to the fruit and veg shop first and then I go to ASDA, I've always just, that's always just been normal to me. (non-client)

On the other hand, Donna was influenced in a very negative way by the area, the availability of shops and the supermarket,

If you don't drive you've basically got two options, ASDA or the Concourse and to get the concourse you have to go on the road so it's just convenient to go to ASDA, I used to think it was cheap because I always used to buy the Smart Price, but now I don't buy it so I don't know what the point of me going there is...it's like I need to buy something from every isle, that's what it's like or you find something to buy. (Client)

The built environment did not have the same negative influence on food choice for all participants. It would appear that those with a sense of individual capacity such as Emily and Scarlet (below) overcame these barriers. Scarlet does not drive, and walks to ASDA every week;

ASDA is all there is, we've got a shop over there but their fruit and veg and bread is not fresh and it's quite expensive. I would only go if I was desperate for something. if I'm in the Coni I'll use the green grocers and if I'm at the ASDA I'll just get my fruit and veg from there it just depends. With ASDA though, if there's something wrong with any of it they'll just take it back and they'll replace it. To get to ASDA I walk and I

get the bus back or I walk back. I just put everything on the buggy, you can put quite a bit on there so that doesn't worry me. In ASDA, some of its cheap and some of it's not so cheap, they cater for all types of people but there is a lot of cheap things there it just depends what you buy. I've heard a few people say its costly and a few people say it's cheaper, it just depends what you buy, it actually works out that the amount you would spend on a weeks vegetables is the same amount you would spend on half a weeks ready meals but with the vegetables it's more in one meal, and I find it's a lot cheaper to eat fresh fruit and veg than to eat packet meals...You've just got to get on with it in Skelm, it's the only way of doing it.

(Non-client)

Chapter five highlighted a number of known and previously unknown influences on food choices, on a micro level (nutritional knowledge, cooking skills and equipment etc.), and this chapter has explored influence on a macro level (the built environment and physical access). The accounts given in this section adds a further dimension to food choice influence, participants report being influenced differently by the physical environment and either report the confidence and capability to shop effectively within the particular limits of Skelmersdale or not.

A large review of food desert literature from 1966-2007 was performed by American authors Beaulac, Kristjansson and Cummins (2009). The authors

confirmed the presence of food deserts and their influence on food choice. However, the majority of evidence was from the USA and any food desert literature from the UK regarding their presence and impact on diet remained inconclusive. The authors summaries;

...there is little evidence that socioeconomically deprived areas in the United Kingdom are systematically disadvantaged by food deserts. We do not mean to imply that accessing food in the United Kingdom is without challenges, but more evidence is needed (Beaulac, Kristjansson, & Cummins, 2009, p. 5)

Earlier research from Cummins and Macintyre (2002) add further controversy to the “food desert” debate. The authors criticise the use of only a small number (three) of UK studies for the basis of highly pivotal Government policy on food poverty and comment that, the “term food deserts became convenient shorthand for a complex problem” with a simple solution. Food deserts are a problem that actually accumulate from a number of variables such education, income, nutritional knowledge, car ownership and area of residence. With its high profile status given by Government policy, the use of the term snow-balled and became a factoid meaning “assumptions or speculations reported and repeated until they are considered true”. The Food Standards Agency investigation on the diets of low-income groups (Nelson, Erens, Bates, Church, & Boshier, 2007) found that 80% of participants shopped at large supermarkets, and in most cases travelling time was less than 30 minutes whether this was by car, taxi, bus or walking. However the FSA article by

Nelson, Erens, Bates, Church & Boshier (2007) did note significant differences in food consumption or nutrient intake according to the main shop used, in that women consumed higher amounts of fruit and vegetables if they shopped at a large supermarket. There was a trend towards poor nutrient intakes and nutritional quality of foods in low income respondents and those in the most deprived areas, although these results are non-significant (Nelson, Erens, Bates, Church, & Boshier, 2007).

So, whether food deserts do exist in the UK, as found in a multi-level geographical analysis (White et al., 2004), or whether more evidence is needed, as argued by Cummins and Macintyre (2002), there is general agreement that a better understanding of the environmental mechanisms pertaining to food choice is necessary. Further investigation is needed to unpick the key variables from the environment, to discover who it influences most, and what impact it has on health outcomes such as obesity levels (Dummer, Gibbon, Hackett, Stratton, & Taylor, 2005; Holsten, 2008; Sallis & Glanz, 2006).

Further exploration into the impact of the built environment at an individual level is also required, as Reisig and Hobbis (2000) articulated “the ease with which people access food is a function of more than geography” (p. 138). Dibsall, Lambert, Bobbin and Frewer (2002) discussed the complexities involved in food access. They too found that the impact on food choice with regard to availability and affordability is evident. However, study participants residing in a characteristically reduced food access area considered

themselves to have a healthy diet. The authors concluded that there are possibly other determinants of greater importance such as motivational, psychosocial or lifestyle factors.

Clarke et al. (2004) argue that the vast majority of the food choices we make are “routinised and habitual” and that price and proximity are less important compared with the subconscious decisions made as part of the everyday life. Although the authors do agree that these actions are constrained within our built environment by such aspects as the availability of appropriate transportation, shopping practices are as deeply embedded in our socio-cultural background as any other food consumption practices that convey notions of normality, nurture and status (Clarke et al., 2004). Therefore, it is the influence of the physical space but also our interaction with it (place) that come together to influence food choices. As Hackett et al. (2008) suggest,

People interact with their physical environment in a multitude of ways, controlled and influenced to some extent by wider social-economic, cultural and political forces, such as education, income, lifestyle and beliefs. Indeed, “space” is not simply an objective structure but also a social experience (p. 430).

Clarke et al. (2004) have also defined food deserts. They categorise them as areas which are *perceived* by consumers to have very limited choice (Clarke et al., 2004). As the authors explain, consumers need to be aware of alternatives and for them to be accessible and affordable. Consumers also

need to feel they have a choice and feel empowered to make that choice. For consumers to feel this outlets have to be available physically, economically and socially. As Clarke et al. (2004) explain ““real” choice is always located in specific contexts, defined in space and time, and that the experience of choice is always socially and spatially differentiated” (p. 98).

In the present research, the majority participants reported the routinised nature of their shopping behaviours, how they were a product of their own socio-cultural upbringing or that these behaviours were learnt over time. As with the discussion on food choice above, these shopping behaviours were equally as embedded in the process of socialisation and social norms.

The accounts presented in this chapter described the interaction with, and belongingness to, the environment around them. For this reason, these themes are also particularly interesting with respect to how they relate to individual capacity and community development (CD) theory. Participants, who did not differ in terms of affluence, access to personal transport or locality, either talked about food choice being constrained by the local environment or their capability to overcome it. It would appear that a person’s confidence, their perceived control and ability to problem solve are as much relevant in preparing and cooking a healthy meal as they are in accessing healthy foods. Where food access problems were presented here, respondents either described solving them or being constrained by them.

Popay et al. (2003) examined experience of lay knowledge, place and health related agency for residents of a deprived area compared with an affluent area in the North of England. The authors found considerable difference between the lived experiences of place in respondents from broadly similar circumstances. For example, the authors gave the accounts of Nicola compared with Susan.

There are no compensations for Nicola in the shape of positive relationships with family members or friends. She lives on social security benefits, and is tied to this place she hates, by low income and rent arrears. In contrast, Susan has a job, albeit low paid, and good relationships with family and friends living nearby. Importantly, however, they also differ in the degree to which their self-identities and biographies are bound up with the places in which they live. For Susan, feeling that she knows the people, is 'part of' the place, and 'belonged to it' appears to ameliorate the stresses of living with the troubles on her doorstep. Whereas Nicola notes angrily that she moved to Lanlow 'through no choice', she is amongst strangers and can find no refuge in a sense of belonging (p. 65).

Here in Skelmersdale, where it was found that positive relationships (social networks and social capacity) were limited, connectedness to the locality was low (respondents reported "ending up" in the locality "through no choice of their own"). Further, there was a perception of individual inability to move areas, reflecting low individual agency. However, for a resident in some

employment, with a positive network of relationships and a feeling of belonging, these factors combined to provide a sense of agency to overcome any “problems” that were presented.

The research by Popay et al. (2003) and the findings presented here support the notion that the lived reality of people and places is as much part of understanding the health impact of an area as the physicality of it. Popay et al. (2003) argue that health related action and health status is connected with the meanings people attach to place, people’s ability to construct a positive identity for themselves despite a poor environment. The ability to do this is linked to normative constructions of place, identity, belonging to and/or separateness from others. These factors shape individual (and collective) agency, and this can be as much regressive as progressive.

Reisig and Hobbis (2000) and Caraher, Dixon, Lang and Carr-Hill (1998) and Lang and Caraher (1998) have previously discussed the role of public health policy and public health practitioners in relation to food deserts and have noted their limitations in terms of the structural influences on food access. However, this unique situation of a comparison with clients and non-clients of a community food initiative has enabled new insights into their efficacy in connecting people with places and, people with people. As Popay et al. (2003) have explained in their paper that community initiatives have the ability to maintain people in place as places are being improved.

As previously noted, client participants reported a sense of belonging and community as a result of attending the community intervention. It was also found that the food workers had the ability to cut across unseen boundaries within the area, improve the *perceived* availability of healthy food in Skelmersdale by encouraging the use of other local shops and for individual capacity (self-efficacy, control, self-esteem and empowerment). Hackett et al. (2008) suggested that food workers who are familiar with areas and are aware of boundaries and territories that are not officially recognised are ideally placed to “instinctively” appreciate the link between the local environment and eating habits.

7.4 Conclusion

The evidence presented in this chapter exemplifies the structural impact an area can have on food choices and contributes to the existing body of literature on food deserts. Further to this, the research confirms the importance of the habitual and unconscious decisions engrained in everyday decisions that is to do with our historical, cultural and social identities. Most uniquely this research has discovered the element of capacity (agency) is most important to overcoming these barriers and impact on health.

This research on geographical influences on food choice highlights the contribution that health services can make to work alongside environmental and housing redevelopments for an integrated approach to dealing with the clustering of health inequalities in disadvantaged areas.

Chapter Eight:

Conclusions

8.0 Summary of the thesis

This thesis was a complex and multi-layered project. The initial research in Skelmersdale set out to determine the food choice influences for mothers of young children. From the results of this initial investigation it became clear that food choices were more complex and inter-related than indicated by previous study methods. The argument presented in this thesis is that ethnographic fiction provides a means by which food choice can be better investigated, understood and reported.

8.1 Summary of the research findings

The first objective of this thesis was to examine the food choice influences for mothers of young children in Skelmersdale to develop a deeper understanding of the wider socio-economic influences on food choice.

Although income is a mediating factor in obtaining a healthy diet and participants identified themselves as being on low incomes, this was not seen as one of the main barriers to a healthy diet. Food fulfils a role beyond nutrition. It acts as a symbol of class and gender identity and of commensality, which influence our food choices in a way that is habitual and unconscious

(See Scarlet in section 5.3 and Sue in section 6.1). To suggest that we are rational, autonomous human beings with the ability to choose if we so desired is to discount the wider social forces influencing our food choice decisions.

This research put women at the centre of food choices within the household. The participant women bore the majority of the responsibility for this pivotal stage of development of their young children. They were mindful of the influence they could have on the health status of their children for the years to come. This research demonstrated that mothers in this life stage were aware of the consequences their actions can have and they were looking for support to guide them through it. This presents a definite window of opportunity for the right intervention whereby mothers are given appropriate and acceptable information, delivered in an accessible way that enables them to take control of their food choices.

The influence of cultural norms and of socialisation were found to be two of the main forces impacting on study participants. The behaviours and practices learnt in childhood were the ones that persisted into adulthood and which are passed from generation to generation. The views of family and friends were considered much more important compared with that of health professionals such as health visitors and GP's (see Figure 4.4, Chapter 4).

An investigation into the geographic influence of the Skelmersdale area reaffirms the impact the physical environment can have on food choice in

terms of what is available and how we interact with the environment. This was particularly profound in participants who had limited transport or no access to a car, in an area with one superstore, expensive smaller retail outlets and that is, difficult to navigate on foot due to town planning and perceived personal safety issues. Food access, availability, nutritional awareness, cooking skills and cooking confidence have also been implicated as mediating factors in the food choice literature (Caraher, Dixon, Lang, & Carr-Hill, 1999). However in this study, these were found to be lesser influences compared with that of social norms, networks and individual capacity.

Individual capacity that is, the ability to operate outside of social norms or physical and structural environmental forces, to problem solve and perform in a manner acceptable to participants, was shown to be the most significant factor influencing food choice regardless of income, education or access. For participants, a sense of individual capacity overcame other wider structural, social and physical environmental forces. An interpretation of the influences on food choice by community development (CD) theory further contributes to the structure and agency debate which has received much attention from Bourdieu (1984), Burger and Luckmann (1966) and Bottero and Prandy (2003), among others. Where there was a lack of individual capacity “lesser” important food choice influences (determined in the hierarchy of food choice, see Figure 4.4) had a greater impact e.g. children’s food preferences, cooking skills, time available to cook.

The second objective of this thesis was to examine the role of a community food initiative in addressing these food choice influences. A comparison of the determinants of food choice for food initiative clients and other persons (non-clients) was used to broaden the scope of food projects to the unintended outcomes. Incorporating non-clients into this research added a further dimension of clarity in the discussion on food choice influences; it provided a comparison group that allowed the impact of a food initiative to be assessed whilst considering any confounding factors within the community. It was the evidence from non-clients that confirmed the importance of individual capacity, which for them was more likely a result of participant's social norms, social networks and their family upbringing. These findings also revealed how socialisation and social networks can be as restricting as well as enabling, for example in the case of Scarlet (in section 5.3) and Kathryn (in section 6.1).

Analysis of the discourse from clients showed how the approach taken by a food initiative, that utilised the community food worker (CFW), tackled the wider forces. CFW's provided appropriate advice cognisant with the experiences of mothers in Skelmersdale by virtue of them being *from* the community and delivering to groups *in* the community. Clients that used the initiative were able to build social support networks that strengthened their sense of individual capacity (see Emmy, section 6.2). For this reason the CFW's instilled a sense of control and capacity which had the knock-on effect that enabled clients to overcome the "lesser" influences on food choice, such as the time available to cook, cooking confidence, child food preferences and food access (see for example Angela in section 5.4) . These findings further

supports the evidence for the use of CFW's for developing healthier food choices highlighted in a previous study in Knowsley, Liverpool (Ellahi & Gregg, 2006).

The acknowledgement that individuals are not always able to make the healthy choice due to wider social forces such as family and social norms is a crucial aspect understood by the CFW. This is because their identity is linked to the area in which they work.

This research revealed that people attended the initiative for other reasons than those intended by the project. For example, people attended to meet others in a similar situation to themselves, to generate a "community" of support and to receive appropriate advice, to get them through an uncertain life stage, something which they had failed to achieve from health professionals. However, there was a disconnection between the outcome measures intended by the food initiative such as improvement in cooking skills, nutritional knowledge and cooking confidence; factors that were not lacking in most participants (see Angela in section 5.4).

This practical examination of a community food based initiative through the theoretical perspective of CD provides an explanation of the main food choice influences and the role of a community initiative for addressing these influences. This study has determined that dietary change in this context of Skelmersdale is predominantly driven by community development outcomes

and as such should be the approach for any community based food and health initiatives.

It is also concluded from these findings that the approaches used to evaluate community food interventions should be open to the outcomes of CD, shown so pivotal to food choice in this research, such as capacity, social networks, problem solving and control. This also extends to the use of methods that can recognise how food choices are constructed by the social environment. If not, projects fail to recognise their worth and role in the promotion of health.

8.2 Research contribution to knowledge

Central to the thesis of this research is the use of ethnographic fiction to enable a better understanding of food choice and the approaches used to alter them. Ethnographic fiction was used as a tool to convey a better understanding of people and of the role and impact of an intervention upon the wider processes involved in food choice. Ethnographic fiction was used here for the first time in public health nutrition to explain the complex picture of food choice for mothers of young children in Skelmersdale. Ethnographic fiction was used within the aims of this study to convey new insight on food choice and the complexity of food choice influence.

Over conventional methods of qualitative enquiry, ethnographic fiction provides a continual narrative that allows thick description of participants lives. As the narratives are rebuilt around themes, they are both faithful to the data

and produce coherence for the reader rather than isolated quotes. Finally, although data was fragmented as part of the analysis process, ethnographic fiction attempts to engage with qualitative interview data in a non-reductionist manner (C.F. feminist critiques of science e.g. Sandra Harding or post-colonial critiques e.g. Nandy). This allows us into the lifeworld (not just the verbalisation) of the participants (Hecht, 2007). Ethnographic fiction was used to put the participant central to the investigation and to provide a voice to the lesser articulate consistent with the community development process to enhance the understanding of food choice influence for mothers of young children in Skelmersdale.

The picture was unclear on the central influences on food choice. By exploring the context in Skelmersdale, the discourse from mothers of young children toward food choice enables a better understanding of what they are and how they are connected. Ethnographic fiction has enabled a clearer understanding of specific lifeworlds of a given area in ways not revealed by existing methods. This has been made possible by bringing together the interdisciplinary perspectives of public health nutrition and sociology, which has provided a unique perspective to the research presented.

UK public health policy was shown to be lacking in operational strategies that exemplify the Government's commitment to addressing the wider forces impacting on health. "On the ground" the individual ideology is prevailing. By applying a constructivist epistemology to the examination of food choice for clients and other persons (non-clients) and examining a community nutrition

intervention through the perspective of CD, we can now rethink how health policy presents strategies that are capable of tackling the root causes of health inequalities. Therefore, reconnect policy to practice and practice to the experiences of individuals, to achieve this target of engagement with health.

Central to the original contribution of this research is the use of ethnographic fiction to enable a better understanding of the complexity involved in food choice and community development approaches to nutritional change. There were two key questions raised from the examination of literature appertaining to the research. In answer to the question of *what* the most appropriate measures are for reducing diet related health inequality, the answer lies in identifying the real forces impacting on health for individuals (as identified here) and the use of appropriate strategies to address them that is a CD model. To answer the question of *how* these are measured and presented, evaluation needs to move away from the scientific model and recognise the demonstrable ability of a methodology that supports the measurement of the forces that really put barriers up to a healthy diet. Therefore, on the basis of this investigation, an approach that has an understanding of the construction of life worlds and of the discourses used to explain them is recommended, in other words, the use of ethnographic fiction.

8.3 Strengths and limitations of the research

The use of ethnographic fiction over conventional qualitative approaches

The use of ethnographic fiction in the field of public health nutrition is ground-breaking and as such will attract debate. The decision to use this tool was taken to address the limitations of conventional qualitative approaches to data collection, transcription, analysis and reporting. The tool lets us into the life world of the participant (rather than just the verbalisation of it) and therefore, provides a greater understanding of participant experiences. Most importantly, it provided an authentic and truthful representation of participants' lives that produces coherence for the reader rather than isolated quotes. Finally, ethnographic fiction was used specifically to convey the complexity of forces impacting food choice for mothers of young children, it provided a collective of voices showing the connectedness of influences, that were built around themes, to give the mechanism of food choice a complex interwoven explanation (Frank, 2000).

For the use in practice, these fictional stories were placed next to theoretical perspectives taken from wider research not only to try to further understand these influences on health but also to make them accessible and understandable to the practitioner (Sparkes, 2002), Ethnographic fiction locates the participant centrally in the investigation. It gives a voice to the lesser articulate expert (the participant), an aspect at the centre of any

community development process, a process that is never more so emphasised in PHN policy.

It would not be possible to construct and convey the social influences and the emotions involved in food choices using other more conventional methods of data presentation, in this research, it has a specific analytical and explanatory purpose (Coffey & Atkinson, 1996).

The use of ethnographic fiction to understand food choices and the community development process will be the focus of the first publication from this thesis. It is also the intention to publish the unexpected findings around the geography of Skelmersdale and impact on food choice. Finally, the continued importance of women's roles in food choice should be recognised and consequently the importance of the empowerment of women and social networks in relation to food and health.

The potential for further research and limitations of ethnographic fiction

Ethnographic fiction can be used in any location to reveal the specificities of study area and cohorts. There is scope for similar research into the influences of breastfeeding, that is, earlier nutritional influences for babies and toddlers. Ethnographic fictions would be ideally placed to explore the reasons why breastfeeding rates are low in deprived areas and to understand the complexity of the decisions around breastfeeding. This is a research area that Stewart-Knox (2013) has recently identified as lacking.

Using ethnographic fiction showed the importance of expressing voices unable to talk directly about issues in a sustained and coherent manner suitable for the “normal” interview process. It allowed a means by which these voices could be (re)presented and as such could extend to nutritional influences of schoolchildren and of people from different ethnicities.

This research aimed to enhance the use of both qualitative and quantitative paradigms, acknowledging the best of both worlds and their limitations in the process. Ethnographic fiction does not try to substitute for necessary quantitative approaches. For example, the impact of geography was an unexpected finding from this research. There is need for further study to see whether this is unique to Skelmersdale or if it extends to other New Town or deprived areas. There is also the opportunity to integrate Geographical Information Systems (GIS) with the place analysis, this would address the call for further research in the field of “place”, unseen boundaries and perceived access to a healthy diet (Hackett et al., 2008). It would also strengthen the qualitative reports on the lack of food outlets and the difficulty in accessing them.

Finally, there could be opportunity to test some of the theories in this research using robust quantitative study in a larger more diverse population. A larger investigation into the community development outcomes of food interventions would be beneficial to commissioners who need to be sure of the

effectiveness and efficacy of any investment into such community programmes.

The stories and narratives presented here are used to generate a better understanding of people and the causes of diet related health inequalities than would have been possible using conventional qualitative methods. These findings are specific to the women in the study however, they are intended to have wider resonance for other similar situations. The understanding of health inequalities is consistent with public health policy and also provides evidence for a much needed strategy for the implementation of community-based initiatives.

These findings do not downplay the complexity of the task at hand, as the quote by James (2008) below also recognises. Policy makers need to be aware of the many conflicting and contending structural forces on health, the contrasting nature of the strategies to tackle them as different from the scientific model (and therefore the evaluation of them), and having a better understanding of the cause of the problem in each case,

As general initiatives on obesity have only just started we should not be surprised by the very limited information that we have on practical community developments which have been shown to be successful. Developing public health policies to combat obesity is also a much more complex process than we originally anticipated and there are all sorts of political pressures to cope with. ...Community intervention projects are

much more difficult to conduct than simple drug trials. They also involve many different factors and nonmedical sectors, which are hard to evaluate in a rigorous, experimental ways. Therefore, as with most other aspects of Government policymaking, e.g. social and economic, one has to work on the basis of understanding the causes of the problem, evaluate the primary drivers and then identify suitable options for changing the environment. (p.347)

The practicalities and the complexity of evaluating the CD model has also been recognised by Laverack (2005) where the generation of thick description from many interviews and transcripts can be difficult and time consuming to interpret, it is also seen as impractical for practitioners evaluating community development programmes. Laverack (2005) provides a spider web visual representation approach for a concise and measurable format to convey personal experience.

Although the involved nature of the method used here is acknowledged, it is argued that the thick description generated insights that would not necessarily been seen using other methodology. However, narratives cannot be a substitute for numbers and data. This methodology is ideal for generating new knowledge. However, “thick” description will not always provide the necessary data needed when undertaking evaluation processes. Dual approaches to evaluation provide robustness in the triangulation of the data and the depth necessary to enable greater understanding (Garcia, Vargas, Iam, Smith, &

Parrett, 2013; Blom-Hoffman, Kelleher, Power, & Leff, 2003; Caraher & Cowburn, 2004; Carman, 2007; Kennedy & Ubido, 1998; Kennedy, Ubido, Elhassan, Price, & Stephoton, 1999; Rankin, Truman, Backett-Milburn, Platt, & Petticrew, 2006; Smith, Conveney, Carter, Jolley, & Laris, 2004; Wrieden et al., 2003).

The complex nature of community projects due to the jigsaw of strategies, multi-sector working and the short term nature of funding strategies is also acknowledged here, as are the difficulties in the identification and measurement of effectiveness. This was observed by Adams, Witten and Conway (2007) in a complex evaluation of a community project that measured input, outcome and process. However, Adams, Witten and Conway (2007, p153) conclude that “a well planned programme enhances the likelihood of good outcomes” which confirms the findings from this research that is that going to the root of the problem and applying evidence-based approaches will make the evaluation of these projects less complex but none the less challenging.

8.4 Further research and the future of CD activity

The current policy and research context

The most recent public health policy coming from the Cameron administration sets out another “bold reform” of the public health system. *Healthy lives healthy people – the way forward* (July, 2011) states “new approaches to public health” where Local Authorities and public health professionals will be

responsible for public health spending. From April 2013 Public Health England will take sole responsibility for population health and will replace departments such as the Public Health Observatories, regional directors of public health, their departments within the DoH and cancer screening programmes amongst others. These changes are set out in the recent amendments to the Health and Social Care Act (2012) which details that GP's, on clinical commissioning groups, will be responsible for the commissioning of services, how best to manage their budgets and reinvest savings. Local councils will be awarded Government money. However, clinical commissioning groups will have the ultimate responsibility to spend it "locally".

In the current economic climate of recession and national debt reduction, it will be key for GPs to commission services that demonstrate their effectiveness and efficacy (value for money). This may mean that GPs are focused towards the commercial sector, to large national corporations to address diet-related health issues (Weight Watchers/Slimming World).

Kennedy (2008) discussed the appropriateness of the approaches used to engage "hard to reach" groups. That the use of lay community workers provides a cost effective opportunity to deliver community nutrition projects and achieve effective CD outcomes. It is important that any approach used to address diet-related health problems considers the multi-dimension influence on food decisions and the appropriateness of the approaches used to address them.

This research in Skelmersdale was able to determine the main influences on diet-related health for mothers of young children and how to tackle them most effectively. By integrating constructionist methodologies and CD theory, this research has been able to demonstrate the value and worth of a community intervention and describe a wider remit for public health professionals. This research will be useful for practitioners, policy makers and commissioners involved in services that improve public health nutrition.

The latest framework of the British Dietetic Association curriculum acknowledges the wider determinants of health and the integration of these public health determinants. The latest challenge for dietitians and nutritionists will be to see their role as more than “across the table” diet plans and more critically to tackle individual capacity for overcoming social norms, social capacity and place.

8.5 Final conclusions

The stories told here are specific to the study participants but they will have wider resonance for women with young children in the UK and beyond and, outcomes of this research will have important implications on public health nutrition policy.

At some point there has been a disconnection between the ways the everyday person thinks and therefore talks about “diet” and the way public health professionals promote “diet”. The present study provides a better

understanding of the everyday person, their thoughts and values. Health professionals reduce the diet to the scientific model where people are seen in a very limited way “a single parent” or someone from a “disadvantage area” and they appear as a stereotype or a cipher, if this is the case we (as health professionals and nutrition practitioners) will fail. If we see people as thick descriptions of the many forces affecting diet then we will be better prepared to succeed in our public health task of engaging people with their health.

People engage with community interventions for different reasons other than to learn to cook. They meet with others; build their confidence and their individual capacity. These non-intended outcomes do not mean the failure of an intervention to achieve its aims. Rather, it means that interventions require understanding of what is needed to overcome the barriers people confront and measures of ‘success’ which include these broader impacts. Therefore, the focus should not only be the biomedical outcomes (scientific model) or the intended outcomes of community based initiatives, but the “how” and “why” (process). This latter focus on process will enable effectiveness to be demonstrated.

This research, although not addressing all the factors influencing health inequalities, was intended to inform the local and national policy relating to diet inequalities, the practice “on the ground” and to further open up the debate on the causative factors of diet-related health: how both upstream and downstream approaches to address health inequalities are needed. This research was an exploration of the influence a community food project can

have on the food choices of mothers of young children examined through CD theory and presented using ethnographic fictions. The outcomes are now presented to policy makers, professionals and practitioners to examine and implement aspects determined from these findings.

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Appendices

- A Participant information sheets and informed consent
- B Letter to partner organisations and list of consenting community organisations
- C List of Partner Organisations
- D Interview structure
- E Examples of pile sorting exercise photographs
- F The Skelmersdale Community Food Initiative
- G Excerpts from the original SCFI bid
- H The Skelmersdale Community Food Initiative monitoring and evaluation strategy
- I Fruit and vegetable voucher for non-clients

Appendix A Participant information sheet and informed consent

Participant Information Sheet - SCFI Clients

Background Information

Skelmersdale Community Food Initiative (SCFI) has been set up to help improve the quality of life for those living in Skelmersdale. SCFI deliver a range of activities around food and health which include, cook and eat sessions, training days, health promotion days and a fruit and vegetable scheme "Box a Bargain".

The Invitation

You have taken part in activities delivered by SCFI and you are being invited to take part in the evaluation of these activities. It is your choice whether you decide to take part. If you agree to take part you will be asked to take part in an interview. It is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet carefully and discuss it with others. If you have any questions please contact Rebecca Gregg using the information at the end of this information sheet

Who is doing the evaluation?

The evaluation is being carried out by the SCFI Project Evaluator, Rebecca Gregg in partnership with the University of Chester where she is a post-graduate research student, under the supervision of Dr Basma Ellahi.

What is it for?

The purpose of this research is to decide whether Skelmersdale Community Food Initiative is successful in meeting its aims. The research also wishes to explore other influences on food behaviour for mothers of young children in Skelmersdale, and the role of SCFI in this.

Why are you being asked to be involved in the evaluation?

You have been chosen to take part in the evaluation because you are a mother of a young child/children living in Skelmersdale and, you have been attending services provided by SCFI.

Do I have to take part?

It is your choice whether you decide to take part. You are able to drop out of the research at any point without this affecting your position at SCFI.

What will happen if I decide to take part?

You will be invited to participate in a one-to-one interview. The interview will be recorded using an audio digital recorder and should take no longer than 1 hour to complete. The interview will take place at a location and time of your convenience e.g. at a Children's Centre, SCFI offices or your own home. The interview will be used to discuss your involvement with SCFI and any influences this may have had on you and your food behaviour and, the factors that influence your food choices as a parent of a young child/children.

The interview will be typed up and posted to you for you to read through, you will be asked to check the content of the interview. If you are happy with the content you will be required to post it back (you will be provided with a stamped addressed envelope).

You may be contacted to take part in a second interview to further discuss issues that may emerge from the first interview. It is your choice whether you decide to take part in a second interview.

Will my involvement be kept confidential?

All data will be anonymised and kept confidential and will only be used for the purposes of this research. You are entitled to a summary of the report at the end of the research which will be available on request from Rebecca Gregg (see details below)

What will happen to my information?

The information you provide will be used in a report for the funders of this research, the National Lottery, Big Lottery Fund. The results be used to inform future funding of public health initiatives to address diet related illness in Skelmersdale. The information will also form part of a research thesis to be held at the University of Chester.

What are the possible benefits of taking part?

As a participant it is possible that you may welcome the opportunity to share and discuss your views and experiences. By taking part, you will be contributing to the development of a service through sharing your views, which will hopefully benefit your community in the future.

What if something goes wrong?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the School of Applied and Health Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence (but not otherwise), then you may have grounds for legal action but you may have to pay for this.

Who do I contact for my questions?

If you have any questions please ask the Researcher/Project Evaluator (Rebecca Gregg) or send them to: Rebecca Gregg, Department of Biological Sciences, University of Chester, Parkgate Road, Chester. CH1 4BJ. Or email:

If you have any questions regarding the conduct of the evaluation please contact the Evaluation Co-ordinator, Dr Basma Ellahi on, Tel: 01244-513125, Email:

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION.

Participant Information Sheet - General Public

Background Information

This research aims to develop an understanding of the influences involved in dietary change, to inform future attempts in preventing an ever increasing rise of diet related illness. The research wishes to focus on mothers of young children as research shows us that this is a key time in the development of food habits for mother and child.

The Invitation

You are being invited to take part in an interview to discuss the factors that influence what you and your family eat.

It is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet carefully and discuss it with others. If you have any questions please contact Rebecca Gregg using the information at the end of this sheet.

Who is doing the research?

The research is being carried out by Rebecca Gregg, a post-graduate student at the University of Chester.

What is it for?

The research wishes to explore the factors that are involved in food choices for mothers of young children in Skelmersdale. It is hoped that the results will enable the improvement of services for parents and children.

Why are you being asked to be involved in the research?

You have been chosen to take part in the research because you are a mother of a young child living in Skelmersdale.

Do I have to take part?

It is your choice whether you decide to take part. You are able to drop out of at any point. Your decision to not take part or to cease involvement in the research will be kept confidential.

What will happen if I decide to take part?

You will be invited to participate in a one-to-one interview. The interview will be recorded and should take no longer than 1 hour to complete. The

interview will be used to discuss the factors that influence your food choices as a parent of a young child/children in Skelmersdale.

You may be contacted to take part in a second interview to discuss these issues in more detail. It is your choice whether you decide to take part in a second interview.

What will happen to my information?

The information you provide will be used in a report for the funders of this research, the National Lottery, Big Lottery Fund. The results will be used to inform future funding of public health initiatives to address diet related illness in Skelmersdale. The information will also form part of a research report to be held at the University of Chester.

Will my involvement be kept confidential?

All data will be kept confidential and will only be used for the purposes of this research. You are entitled to a summary of the report at the end of the research which will be available on request from Rebecca Gregg (see details below)

What are the possible benefits of taking part?

As a participant you may welcome the opportunity to share and discuss your views and experiences. By taking part, you will be contributing to the development of a service, which will hopefully benefit your community in the future.

What if something goes wrong?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the School of Applied and Health Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

Who do I contact for my questions?

If you have any questions please ask the Researcher (Rebecca Gregg) or send them to: Rebecca Gregg, Department of Biological Sciences, University of Chester, Parkgate Road, Chester. CH1 4BJ. Or email:

If you have any questions regarding the conduct of the evaluation please contact the Evaluation Co-ordinator, Dr Basma Ellahi on, Tel: 01244-513125, Email:

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION.

Consent Form

Please **complete** and **return** the section below if you wish to take part in the evaluation.

Please Tick

1. I confirm that I have read and understood the Information Sheet and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and it will not affect my position at SCFI. ☐
3. I understand that I will be recorded with an audio digital recorder as part of the research ☐
4. I understand that that the results of the research will form part of a research dissertation and will be available from University of Chester and that if I request it I will receive written feedback at the end of the evaluation. ☐
5. I understand that in order to keep the information I have given confidential, all information will be coded and securely stored and will only be available for the purpose of this evaluation. ☐
6. I agree to take part in the above study

Name of Participant

Date

Signature

Name of Person taking
consent (if different from
researcher)

Date

Signature

Researcher

Date

Signature

Appendix B Letter to partner organisations and List of consenting organisations

Rebecca Gregg
Post-Graduate Researcher
University of Chester
Parkgate Road
Chester
CH1 4BJ

Tel:
Email:

Dear Sir/madam

Re: Research Study – Dietary change in the community

Following our conversation on [date], I have enclosed background information regarding the research.

Your organisation is being invited to take part in a research study. The research is being carried out by Rebecca Gregg and aims to investigate the process of dietary change in the community.

Rebecca Gregg is a post-graduate student at the University of Chester and as such has been recruited by Skelmersdale Community Food Initiative to evaluate scheme activities. As an extension to the evaluation, this research aims to compare the influence of SCFI in changing the food behaviours with, the influence of outside factors on eating behaviour i.e. your and other public health initiatives.

As research shows us that mothers are key influences in the development of food habits early in life. The research aims to use interviews to talk to mothers of young children about the influences on food choices (twenty-five who have been involved in SCFI and twenty-five who have had no involvement with SCFI). The research is only interested in the influences facing mothers of young children in Skelmersdale.

Please continue to read the research summary attached. If you are interested in taking part in the research or you feel your organisation may benefit from participation in this research a meeting can be arranged to further discuss the involvement of your organisation and clients.

Yours sincerely,

Rebecca Gregg

Appendix C List of partner organisations

Oaks Children's Group

Park Children's Centre

Skelmersdale Ecumenical Centre

Skelmersdale Home start

St. Johns Children's Centre

Appendix D Interview structure

Interview Guidance

INTRODUCTION AND TALK THROUGH INFORMATION SHEET AND INFORMED CONSENT

For Clients of SCFI ONLY:

Above plus;

Impact of SCFI and the activity

- Motivations for participation
- Outcomes of participation
- Cascade of effects onto others?

Aspects of SCFI leading to change

- Role of CFW
- Attitudes towards advice

Issues for ALL participants:

The shaping of patterns around food and eating

Situatory behaviour

- Feelings around food, health and the importance of good nutrition
- Motherhood and impetus to change food behaviours
- Accessibility, affordability, availability, acceptability issues in Skelm
- Attitudes towards nutritional advice – weaning
- Community development (CD) aspects – Confident cook, self-esteem, capacity 'to do', knowledge of nutrition
- Affiliation
- Other person influences

Participant profile Info: Time, Space and People Relations

Person

Age

Partnership status/housing arrangements

Children and ages

National regional origin

Family links (parents, siblings)

Access to food

Where shop

How travel

How far/long to shops

Own shopping behaviour

Regularity of shopping

How many shops used – supermarket, grocer, butcher

Food and eating processes

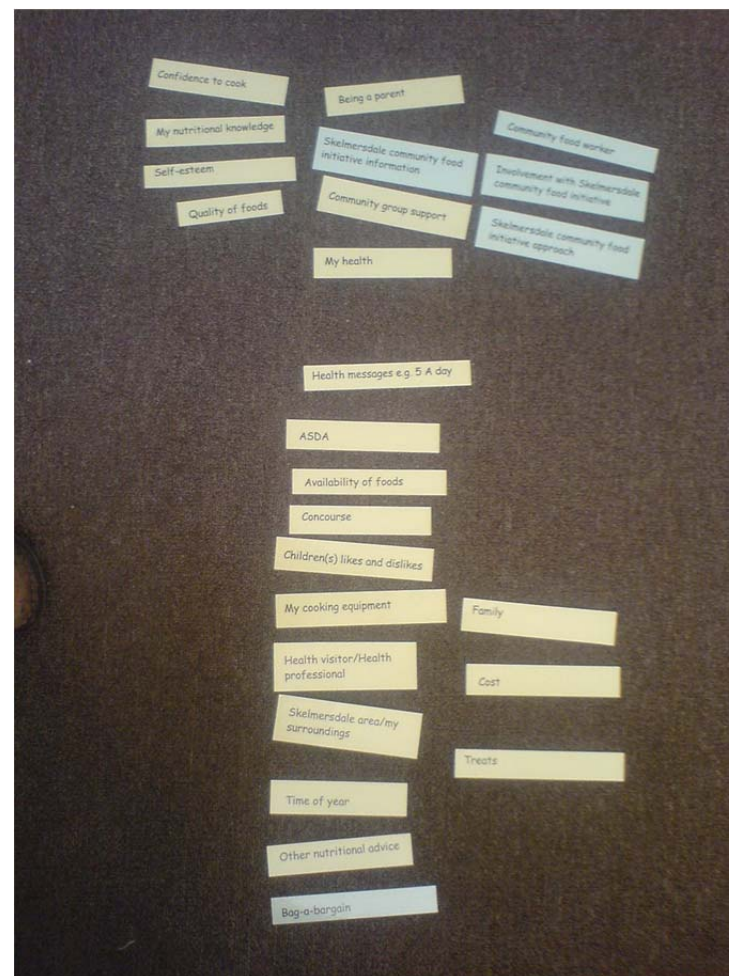
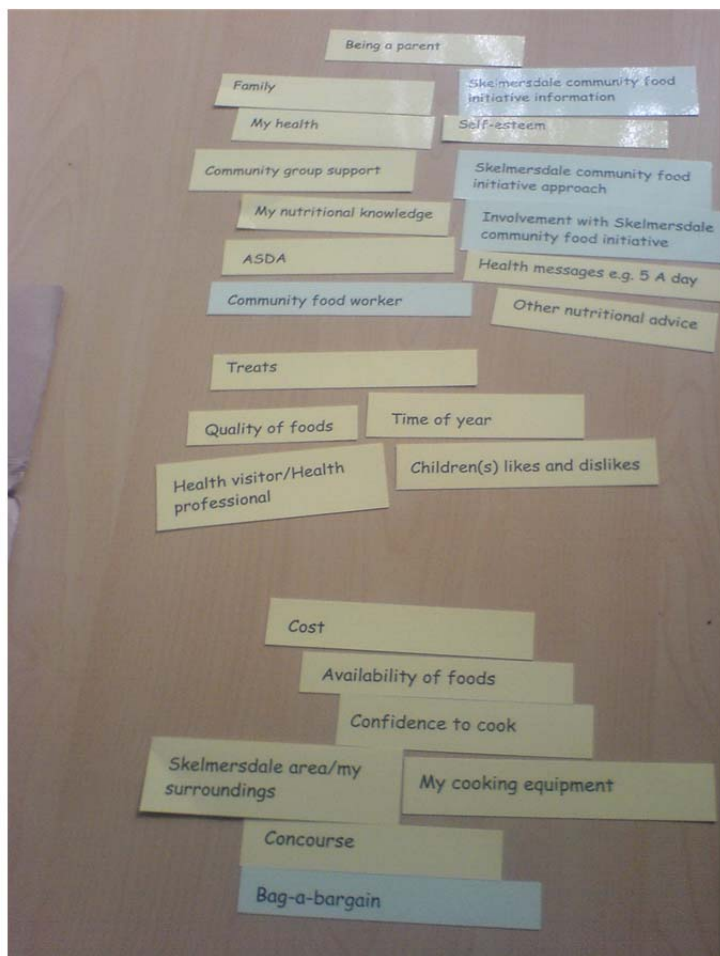
Eating - How often/mealtimes

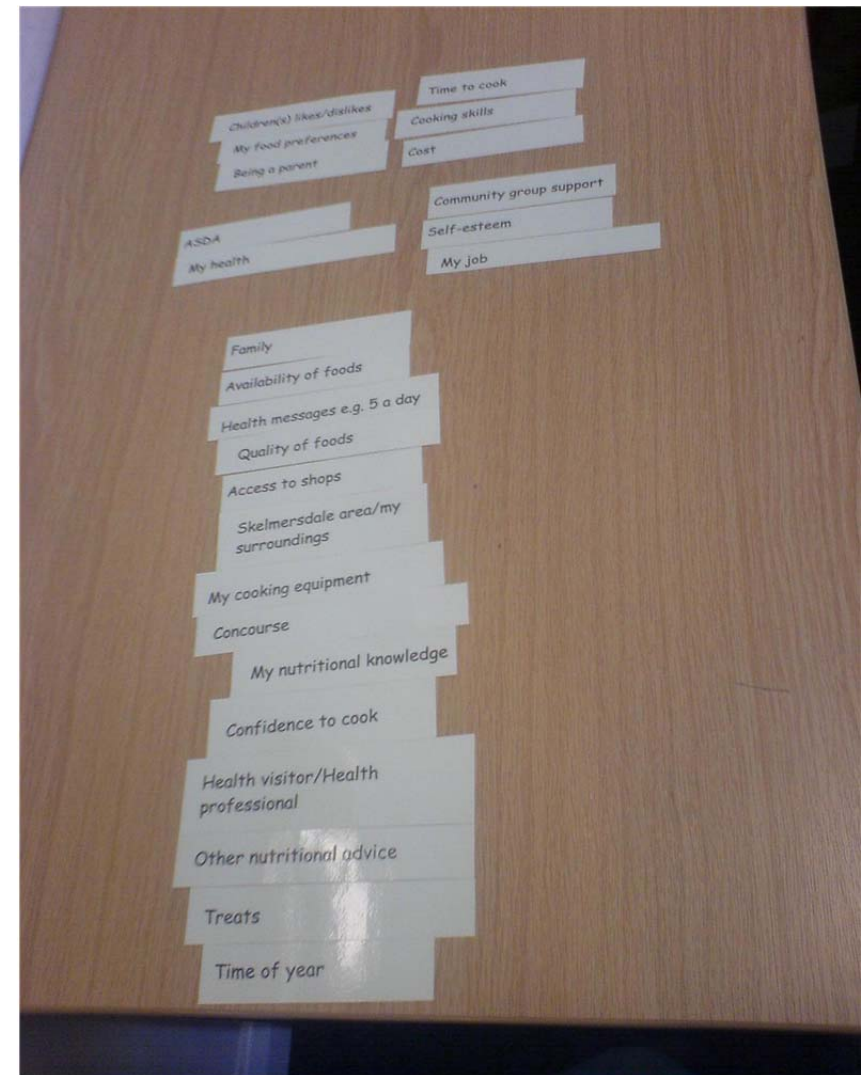
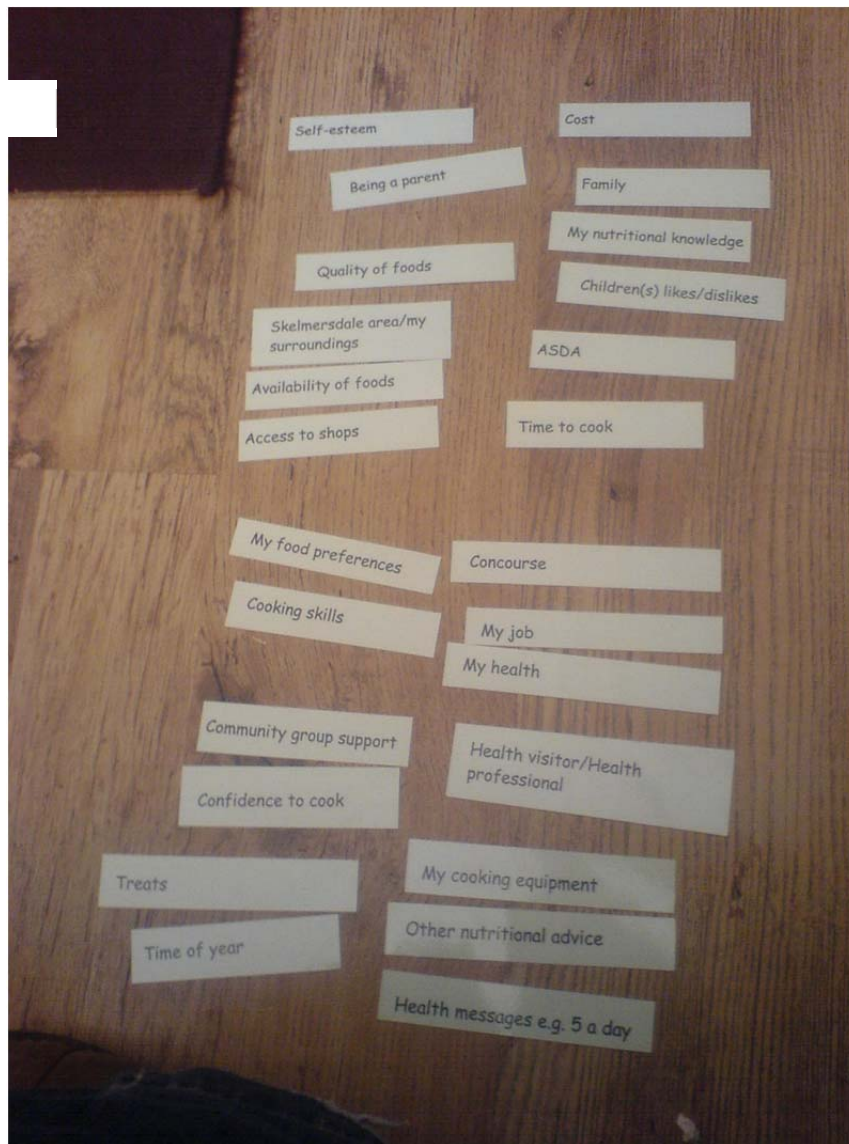
What sort of food/cooking

Before and after children

With/without partners or others

Appendix E Examples of pile sorting exercise photographs





Appendix F The Skelmersdale Community Food Initiative

SCFI was a Healthy Living Centre programme. The Health Living Centre (HLC) initiative was proposed to support Government objectives stated in the white paper; *Saving lives; Our healthier nation* (DoH, 1999b). HLC's were established in the most deprived communities around the UK to promote health and reduce health inequalities through the implementation of community lead initiatives. HLC's aim to involve the community, work in partnerships with other community organisations and work towards implementing sustainable changes (Meyrick and Sinkler, 1999).

The Skelmersdale Community Food Initiative is a Healthy Living Centre programme originally funded by The Big Lottery Fund (previously the New Opportunities Fund) and UK Government Single Regeneration Budget. The one-million pound initiative was established in January 2003, and in this incarnation was initially funded until January 2008. Currently it is part of the wider "Wellbeing Portfolio" of projects funded by the Big Lottery Fund through the Northwest Healthy Living programme until October 2012. The overriding aim of the initiative was to: "promote the health and wellbeing of Skelmersdale residents by encouraging informed lifestyle choices with specific reference to food issues."

Box a SCFI project aims and objectives

The overall aim of SCFI was to promote the health and wellbeing of Skelmersdale residents by encouraging informed lifestyle choices with specific reference to food issues.

The strategic objectives of SCFI were to:

- Assist in developing and supporting a range of projects which help to improve food access and availability.
- Introduce food projects which will improve the nutritional awareness of those living in Skelmersdale
- Utilise food projects as a means of securing community development.

Activities focused on health improvement and looked to address health inequalities by:

- Responding to local people's concerns about their health with practical support and advice in a context which can facilitate change e.g. cook and eat sessions that incorporate the prominent obstacles to a healthy diet in particular population groups
- Developing and supporting activities which help improve access to safe, affordable and nutritious food e.g. food co-operatives and community fruit and vegetable schemes
- Creating and developing effective local health partnerships with private, public and voluntary sector organisations e.g. with Central Lancashire Primary Care Trust (PCT), Sefton PCT and West Lancashire Council for Voluntary Services (CVS)
- Engaging the community in actively promoting health and sustaining progress e.g. using volunteers for the continuation of SCFI activities beyond scheme involvement

SCFI operated out of a central location, the Ecumenical Centre, a united church and community centre in Skelmersdale. The project Management Board consisted of key stakeholders from the Skelmersdale community who oversaw project operations. At the time of the research, SCFI employed a team of ten staff, which included five community food workers, a public health nutritionist and a project co-ordinator. SCFI also relied on a number of volunteers to support their activities.

Appendix G – Excerpts from the original SCFI bid

SECTION TWO: PROJECT DETAILS

2.1 OUTLINE

2.1.1 Project description

Please summarise your project. Tell us if it is new or existing, whom it is for, what activities or services the project will deliver and how and where the project activities will take place. If you are developing an existing project further, what new activities or services will you be providing?

WHAT

This is a new project, which aims to address the serious health, social and economic inequalities in Skelmersdale by supporting and developing imaginative, practical and sustainable, community-based food projects, which help people take greater control over their individuals and community lives. Four major objectives will be to

- o Create a network of 4 sustainable food co-operatives; improving access to good quality, affordable food.
- o Establish a Community Nutrition Project, e.g. developing 'cook and eat' sessions to enhance cooking skills, initiating projects with vulnerable groups, building links with schools and young people.
- o Support new community-based food projects, such as community shops, cafes, which will be owned, managed and run by local people.
- o Create local jobs for local people - one full-time post of Project Manager and 8 part-time posts. These consist of 4 Community Nutrition Workers, 2 Development Workers, one Clerical Administration Support worker and one Community Dietician.

WHO

The project is open to all residents of Skelmersdale, but we are particularly targeting people on low incomes with limited access to transport, mobility problems and/or caring responsibilities, for example:

- Single parents
- Isolated older people
- People caring for an elderly, disabled or sick relative
- People with disabilities, or chronic illness which restricts their mobility
- Unemployed people
- Children and younger people - for example, linking with the Surestart initiative

WHY

- o Skelmersdale is a 'new town', built in the 1970's to house a population over-spill from Liverpool. Its current population is approximately 43,000. The town was blighted by the recession of the 1980's- before building had even been completed. Originally planned for 80,000, The town is still without basic central, civic amenities e.g. there is no cinema, no town hall, no café or restaurant open in the evening. Many of its large employers moved out in the 80's, and the town suffers many of the multiplicity of problems more often associated with inner city areas. All the main food retailers are based in the town centre; provision on the housing estates is expensive, poor quality - and very limited. Public transport is virtually non-existent.
- o Poor diets are one of the major risk factors of coronary heart disease and cancer and the people of Skelmersdale not



only experience rates well above the national average but have also one of the highest rates for these diseases in the North West (DPH Report, 2001).

- o The project will develop and maintain links with other strategies to reduce the risks of coronary heart disease, such as physical activity strategies to reduce the risk of cancers, e.g. linking in with Exercise on Prescription.

WHERE

We envisage the administrative base of the project will be in a community-based building in the town centre. However, the core activities of the project are all built on community outreach work - and it is envisaged that these will be carried out at a whole range of community venues throughout the town.

Management of a number of small community centres has recently been taken over by individual community groups and consortia - and some of these would provide a natural centre of activities. This is particularly timely, as the new management groups are keen to develop these buildings as neighbourhood resource centres and want to positively support new activities. Larger community centres are scheduled to have major improvements carried out in the next two years - and again these would be a natural location. Plans for the community centres have included community cafes, childcare facilities. The four local Estate Management Boards are all keen to support new community initiatives - Skelmersdale Community Food Co-op, for example, has been supported by Digmoor Estate Management Board for three years - providing free premises and use of their facilities.

2.1.4 What is the overall aim of your project? Please give a short summary of what you ultimately want to achieve.

The project aims to address the serious health, social and economic inequalities in Skelmersdale, by supporting and developing imaginative, practical and sustainable community-based food projects, which help people take greater control over their individuals and community lives.

We aim to establish a network of sustainable, inter-related community enterprises and services, which improve health, social and economic well-being in Skelmersdale; these include a community nutrition project, establishing food co-operatives, community cafes, community shops etc. We envisage these will continue after the end of this project - the community nutrition project becoming part of mainstream provision, and the community food enterprises being self-sustaining.

This project is based on the belief that local people are the best placed to define their own needs, and are the best equipped to work in their communities tackling the problems they face. It is built around creating local jobs for local people, providing the skills, training and support necessary to enable people to design, deliver and run this project. People and partnerships are the key to its successful delivery.

We aim to empower, enable and involve local people in Skelmersdale, in the planning, implementation and management of a community-based food project which, in turn, will empower local people via support, nutritional advice, education, and improved access to good quality, affordable, nutritional food.

Appendix H

The Skelmersdale Community Food Initiative monitoring and evaluation strategy

The evaluation of this initiative was granted by contract to Dr. Basma Ellahi a public health nutritionist, head of the Department of Clinical Sciences at the University of Chester. This enabled the employment of Rebecca Gregg as Project Evaluator who was situated in the project and worked with collaboratively with the project on a day-to-day basis to plan and implement the evaluation.

The monitoring and evaluation (M&E) strategy was designed to assess and maintain SCFI's commitment to the community. This was in relation to delivery outcomes and to improve evaluation capacity among the SCFI workforce. The strategy was designed to investigate the three strategic objectives of SCFI which was examined through the following research questions and nutrition and health related outcomes expected as a direct result of participating in project activities (see Box b).

The clients of the SCFI are at the centre of this research. Data used for the evaluation of this project was collected with a dual agenda; firstly to address the evaluation of SCFI and secondly, to explore the wider influences and food choice and the possibility of unintended outcomes. Both the project and participants were aware of this and consented for the data to be used in the production of this report.

Box b Research questions and envisaged nutrition related outcomes of the SCFI

Question One

Is the scheme effective at assisting in developing and supporting a range of projects which help to improve food access and availability?

Outcome measure

The support and development of projects that improved access to good quality, affordable, nutritious food

Question Two

Is the scheme effective in introducing food projects which improve the nutritional awareness of those living in Skelmersdale?

Does the scheme improve knowledge of nutrition of those in Skelmersdale?

Does the scheme improve food skills of those in Skelmersdale?

Is the scheme effective in changing the eating behaviours of those in Skelmersdale?

What role does the Community Food Worker (CFW) have in facilitating these?

Outcome measures

Participants opinions and observations of improved nutritional knowledge, food safety, reports and observations of improved practical domestic skills, self reported details of improved dietary habits supplied by participants.

Question Three

Is the scheme effective in utilising food projects as a means of securing community development?

Does the scheme build capacity, empower and engage those involved?

Does the scheme build effective partnerships with the community and local health organisations?

Outcome measures

CFW observations and participant views of improved confidence and self-

esteem. Monitoring data on partnership working and partnership organisation views and opinions.

Question Four

Is one type of activity more effective than another across research questions 1-3

Outcome measure

Comparison of the above outcomes between the range of activities deployed by SCFI.

Question Five

What is the potential for the sustainability in SCFI community-based actions and CFWs?

Outcome measures

Community capacity building measures ie in participants. Evidence of continued funding and, the mainstreaming of SCFI activities and/or workers.

The evaluation report details the key activities and findings and then makes recommendations to inform future practice. A copy of the report can be obtained from the Dept of Clinical Sciences, University of Chester by contacting the principle researcher.

Appendix I – Fruit and vegetable voucher for non-clients

BAG A BARGAIN



VOUCHER

This voucher entitles you to
2 free bags,
with a choice from fruit,
vegetables, salad or mixed.

For further information contact us:
Tel: 01695 720555
Email: scfi@btopenworld.com
Ecumenical Centre, Northway, Skelmersdale